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NURSING HOME CARE: THE UNFINISHED AGENDA (Volume II)

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

NINETY-NINTH CONGRESS

SECOND SESSION

WASHINGTON, DC

MAY 21, 1986

APPENDIX 6: CHRONOLOGY OF INTERNAL DOCUMENTS PERTAINING TO MONITORING AND ENFORCEMENT OF FEDERAL HEALTH AND SAFETY STANDARDS IN NURSING HOMES

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APPENDIX 6

INTERNAL DOCUMENTS PERTAINING TO MONITORING AND ENFORCEMENT OF FEDERAL HEALTH AND SAFETY STANDARDS IN NURSING HOMES

DEPARTMENT OF HEALTH & HUMAN SERVICES

Memorandum

Date March 11, 1981

From Edward L Kelly
Edward L. Kelly, Acting Director
Health Standards and Quality Bureau

Subject Revised FY 1981 and FY 1982 Budgets for Medicare and Medicaid Survey Activities

To Regional Administrators, HCFA
Regions I - X

The revised FY 1982 Budget submitted to the Congress by President Reagan on March 10, 1981 provides funds to support Medicare and Medicaid survey activities as shown in the following table:

(Dollars in Thousands)

	FY 1981			FY 1982		
	Current Budget	Revised Budget	Change	Current Budget	Revised Budget	Change
Medicare Survey Activity	$29,760	$23,760	-$6,000	$26,535	$17,500	-$9,035
Medicaid Survey Activity	$36,140	$36,140	--	$33,165	$33,165	—

Except for the proposed legislation to cap Medicaid, the proposed budget makes no specific change in survey and certification under Medicaid. However, the proposed budget would rescind $6 million for FY 1981 Medicare survey costs. The Impoundment Control Act of 1974 (P.L. 93-344) provides that affirmative action by the Congress in the form of an enacted rescission bill must be completed to rescind funds. During its consideration of the President's proposals, the Congress may adjust amounts proposed for rescission. However, if both Houses have not completed action on the bill within 45 calendar days of continuous session, the funds proposed for rescission must be made available for obligation.

The uncertainty of the final outcome poses a major operating and management problem for us. If we do not act prudently and prepare for a lower operating level, should the proposed budget be enacted, we will be drastically short of funds in the last months of FY 1981.

Another problem faces us for FY 1982. The proposed budget for FY 1982 is consistent with the proposed reduction for FY 1981. In other words, if the FY 1982 budget is enacted (with or without the enactment of the proposed rescission for FY 1981) survey and certification activities for Medicare will be drastically reduced. Thus, you should be aware that even if the budget for FY 1981 remains unchanged, we will in all probability be operating at a greatly reduced level in FY 1982.

States must be prepared to immediately phase down to a level which enables them to operate in a manner that will not exceed funds available within budgetary levels approved by Congress.

To prepare the States, each Regional Office should advise State agencies of the reduced program funds available to support survey activities under the proposed budget. Workload estimates/requirements may need to be renegotiated quickly within available funds and facility priorities. To facilitate your discussions, we have included in this memorandum suggestions for streamlining the survey process, as well as suggested funding by State.

As you know, we have been studying the survey and certification process for several months to determine what actions we could take to streamline the process and make it more efficient. Our original schedule called for a series of issue papers to the Administrator this summer and fall. Due to the urgency of the current budget situation, we have accelerated our schedule. Nevertheless, a number of these changes will require top level approval, the development of criteria and computer screens, and regulatory and legislative changes — all of which take time.

In the interim, to assure that survey activities conducted during the remainder of the fiscal year reflect national and Regional priorities, we are providing the following guidelines to assist you in the management of the survey and certification process under the proposed budget.

1. Skilled Nursing Facilities

Surveys of skilled nursing facilities (SNFs) will remain the highest national priority. Budget renegotiations with Stage agencies must provide the necessary financial support for required SNF surveys during the remainder of FY 1981. If necessary, Medicare survey resources in Regional Office allocations should be reallocated among the States based on the number of Title XVIII SNFs which are yet to be surveyed. No funding should be allocated for other providers or suppliers until required funding has been provided for all SNF surveys.

SNFs should continue to be surveyed as scheduled, with the following suggestions providing you some additional flexibility to minimize costs for Title XVIII surveys.

(a) Size and Composition of Survey Teams

SNF surveys could be conducted, whenever possible, by less than a full survey team. The State agency and Regional Office should review the Individual Facility Profile (IFP) generated by MMACS to determine the qualifications the surveyor(s) should have based upon the facility's past performance. For example, if the SNF has historically complied with program requirements, a generalist surveyor might suffice. If, on the other hand, the SNF has been cited for nursing service problems, a nurse should be sent.

(b) Consultation Visits

Visits for consultation could be discontinued for the remainder of the fiscal year.

(c) Post-Survey Followup Visits

(i) Followup visits need not be made when a SNF has been issued a full 12-month agreement without conditional clauses.

(ii) When a conditional period or short term agreement has been issued, an onsite visit could be made to the SNF only when no other method can be used to verify whether the required corrections have been made. For example, no onsite visits need be made to verify corrections of deficiencies in personnel requirements, internal organizational structure, or provider policies.

(d) Life Safety Code Surveys

Life Safety Code surveys, as currently performed, could be discontinued. Life Safety Code surveys could be conducted only in the case of initial surveys or when there have been structural modifications in the provider's physical plant.

(e) Surveys Following Change of Ownership

Judgment should be used to determine the need for routine onsite surveys following a change in ownership.

2. Non-Long Term Care Surveys

The preceding guidelines affecting surveys of Title XVIII SNFs should be applied before considering surveys of other categories of providers. After funding has been provided for SNF surveys, the Regional Office should allocate any remaining funds toward surveys of those facilities within the Region or within individual States which have the highest priority.

The suggested order of priority for the allocation of any remaining survey funds is as follows:

(a) Complaint surveys

(b) Independent laboratories

(c) Non-accredited hospitals

(d) All other

3. Proposed Budget

Attached is a summary chart indicating suggested allocations by Region and by State for the proposed budget.

Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES

0 5 JUN 1981

Jennifer Riseon, Director
Bureau of Quality Assurance
Pennsylvania Department of Health
Health and Welfare Building - Room 1008
Harrisburg, Pennsylvania 17120

Dear Ms. Riseon:

In our meeting of March 20, 1981 we discussed the potential changes that could occur if President Reagan's budget was passed. As you know, this has occurred and we are attempting to identify the Medicare allocation for the fourth quarter of fiscal year 1981 (7/1/81 through 9/30/81). Although we have not received specific information from central office, we have estimated that your allocation is $144,800.

In order to best utilize this funding, the following guidance/recommendation is provided:

A. General Policy to be Followed in the 4th Quarter

1. States will not be able to hire new employees for Title XVIII purposes;
2. No new equipment can be purchased for Title XVIII;
3. States should review the composition of survey teams and use a generalist approach. Only on specific cases where a team is essential should that approach be taken.

B. The Following is the Workload in Order of Priority for the 4th Quarter:

1. All initial Medicare provider and supplier surveys;
2. Skilled nursing facilities surveys and resurveys;
3. Complaint work;
4. Non-accredited hospital surveys;
5. All other activity.

C. Life Safety Code (recertifications only)

In those instances where facilities are in full compliance with the life safety code requirements, Skilled Nursing Facility and Non-accredited Hospital recommendations for certification will be accepted without a life safety code survey providing that the state agency documents compliance and that there are no waivers.

D. Consultation

Except for initials or adverse actions, consultation should be conducted by mail or phone contacts.

E. Cancellation Clause Removals

In the area of cancellation clause removals, the following criteria should be

FILE
COPY

OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE
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ROB		6/4						

applied:

1. on existing cc's, if the cc can be removed by mail or phone, the survey agency should do so;
2. cc should not be established unless a standard is out.

F. JCAH Validation and Monitoring

As indicated at the March meeting, we thought we could remove this activity; however, Central Office has informed us that we need to take action on some of the pending cases. These cases will be handled on an individual basis.

G. IPPTs, Portable X-Rays, Rural Health Clinics, Home Health Agencies, OPT/STs

As we indicated in all these categories, only initials take priority. Only in extreme cases involving serious allegations of life threatening situations should a revisit be conducted.

H. ESRDs

Initials take priority. Resurveys should be conducted only where there are problems. Revisits should not be conducted unless circumstances indicate the need.

We hope this information is helpful. If you need any clarification, please contact your Principal State Representative in the regional office.

Sincerely yours,

Gerald P. Szucs, Ph.D.
Associate Regional Administrator
Health Standards and Quality

JUN 30 1981

DEPARTMENT OF HEALTH AND HUMAN SERVICES
REGION V
175 W. JACKSON BOULEVARD
CHICAGO, ILLINOIS 60604

HEALTH CARE FINANCING
ADMINISTRATION

June 26, 1981

Refer to: PCB-C01

Ross
cc Drake

John H. Ackerman, M.D.
Director of Health
246 North High Street
Post Office Box 118
Columbus, Ohio 43216

Dear Dr. Ackerman:

We have received our Title XVIII Survey and Certification activities budget allocation for FY 1982. The total figure is 26% less than the final amount for FY 1981 which we advised you of on June 17, 1981.

The amount allocated for Ohio is $578,300.

Because of the reduced funding level for FY 1982 the following national priorities have been established:

1. Initial Surveys and Surveys of Skilled Nursing Facilities

   Initial surveys and surveys of skilled nursing facilities (SNF's) will receive the highest national priority. No funding is to be earmarked for other providers or suppliers until required funding has been provided for these surveys.

   (a). Consultation Visits

   State Agencies may furnish to a SNF, after proper request, reasonable specialized consultative services to assist the SNF to meet one or more of the conditions specified in Section 1861(j) of the Social Security Act.

   (b). Post-Survey Follow-Up Visits

   (i) Follow-up visits are not to be authorized when a SNF has been issued a full 12-month agreement without conditional clauses.

   (ii) When a conditional period or short term agreement has been issued, an onsite visit may be made to the SNF only when no other method can be used to verify whether the required corrections have been made. For example, no onsite visits need be made to verify corrections of deficiencies in personnel requirements, internal organization structure, or provider policies.

(c) Life Safety Code Surveys

Life Safety Code surveys, as currently performed should be discontinued. Life Safety Code surveys should be conducted only in the case of initial surveys or when there have been structural modifications in the provider's physical plant.

(d) Surveys Following Change of Ownership

Judgement should be used to determine the need for routine onsite surveys following a change in ownership.

2. Surveyor Training

In recognition of the reduced amount of funds available to State agencies, the offerings of centrally-sponsored courses will be substantially cut back. A listing is attached of training courses projected for the 1982 fiscal year.

3. Non-National Priority Surveys

The order of priority for the allocation of remaining survey funds is as follows:

(a) Complaint surveys
(b) Independent laboratories
(c) Non-accredited hospitals
(d) All other

Please prepare your FY 1982 budget request in accordance with section 4600ff of the State Operations Manual. The total amount requested cannot exceed the amount shown above. Your request should be submitted to our office by July 24, 1981.

We will advise you of the Title XIX FY 1982 funding level next week.

If you have any questions concerning this, please contact your Principal Program Representative.

Sincerely,

Robert A. Cullen

Robert A. Cullen
Associate Regional Administrator
Division of Health Standards & Quality

Enclosure

[SEP 8 1981]

Mrs. Helen O'Bannon
Secretary, Department of Public Welfare
H. Arnold Muller, M.D.
Secretary, Department of Health
Health and Welfare Building
Harrisburg, Pennsylvania 17120

Dear Mrs. O'Bannon and Dr. Muller:

Unlike other years in the Medicare and Medicaid Survey and Certification Program, recent Congressional reductions have impacted significantly on approval of state survey agency 1982 budget requests. The administrative cuts passed in May and the more recent passage of the 1981 Omnibus Budget Reconciliation Act have reduced, especially in Medicare, the monies available for survey and certification activity. Based on these reductions, corresponding changes in program emphasis, and a review of your budget submittal, the Regional Office has approved $834,320 for Medicare, and $1,751,468 for Medicaid in Pennsylvania.

The reduced funding, especially in the Medicare program, is predicated on a decrease in the survey activity for 1982. Enclosed for your information is a list of the emphases in the Medicare program that the Pennsylvania State Survey Agency will be expected to accomplish. More specific information addressing what providers and suppliers are to be surveyed and what information is to be submitted to the Regional Office concerning Medicare providers and suppliers will be discussed at a regional state agency meeting in early October with members of your staff.

Although the next few months will be a period of major transition in the program, we will be available to work closely with you and your staff and provide as much technical assistance as possible.

If you have any questions concerning the attached budget approvals, please contact Rosearn Marsicano at (215) 596-0522.

Sincerely yours,

Gerald F. Szucs, Ph.D.
Associate Regional Administrator
Division of Health Standards and Quality

Enclosure

Medicare Priorities for Fiscal Year 1982

Based on central office guidance, the following are the most current priorities established for the Medicare 1982 workload.

Administrative Guidance

1. Where possible all surveys should be conducted by a generalist surveyor. Where team surveys for special problems are needed, please consult with the regional office.

2. To provide flexibility to the state agency, line-item controls have not been placed on money approved for the fiscal year except for training. This is in accordance with the State Operations Manual (SOM) Part IV, Section 4630(B). Approximately three percent of the approved Medicare and Medicaid budgets have been allocated for training and line item flexibility in this area is not permitted unless approved by the regional office.

3. The regional office will monitor the state agencies closely to determine that the established workload priorities are met. Comprehensive Evaluation Reviews will be conducted on the states' management of the workload priorities.

4. Complaint surveys should continue to be conducted. An on-site visit will be necessary if the complaint directly impacts on the health and safety of patients. However, where it can be determined that an on-site visit is not immediately necessary, the complaint should be conducted during your next scheduled visit. If the complaint is against a Title 18 provider or supplier that you have no plans to survey, please forward that complaint to the regional office for review and follow-up.

Program Priorities

A. Initial Surveys:
Performance of initial surveys of all provider and supplier categories is the highest national priority. We will be requesting that the survey agency submit on a monthly basis a report indicating the number of on site visits in each provider and supplier category for new Medicare participants.

B. Skilled Nursing Facilities
Skilled nursing facilities have the second highest priority. We will be discussing with the State Agency Directors in early October the approach we will take in this area. In the meantime you should consider the following in scheduling this workload.

1. Consultation Visits
Except for initials or adverse actions, consultation should be conducted by mail or phone contact. If on site consultation is necessary, it should be in conjunction with an on site survey visit.

2. Post-Survey Follow-up Visits
Follow-up visits should generally not be conducted. On existing cc's, if they can be removed by mail or phone, the survey agency should do so. An on site visit to a SNF should be made only when no other method can

be used to verify whether required corrections have been made.

3. Life Safety Code Surveys
   Life Safety Code surveys, as currently performed, should be discontinued. Life Safety Code surveys should be conducted only in the case of initial surveys or when there have been structural modifications in the provider's physical plant, or in facilities with serious deficiencies.

C. Non-Long Term Care Surveys
   1. Independent Laboratories
      Schedules should be established to resurvey all CLIA and Medicare participating independent laboratories.
   2. Non-accredited Hospitals/JCAH Psychiatric Hospitals
      Non-accredited hospitals and JCAH Psychiatric Hospitals should be surveyed when serious deficiencies have been defined or if the hospital has a past history of cyclical non-compliance.
   3. JCAH Validations and Monitoring
      Upon regional office requests, this activity will be accomplished.

The Medicare approved budget provides for the completion of the priority workload in order as defined. If additional dollars remain after the priorities have been addressed it should be applied to the remaining workload items in this order:

1. End-Stage Renal Disease Facilities (ESRD)
2. Home Health Agencies (HHA)
3. Outpatient Physical Therapist/Speech Therapist (OPT/ST)
4. Rural Health Clinics (RHC)
5. Portable X-ray Facilities
6. Independent Practicing Physical Therapist (IPPT)

[illegible]
[illegible]

[illegible]
[illegible]

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

MS OB-31

October 8, 1981

Mr. Ronald L. Hansen, Director
Division of Survey & Certification Operations
Health Standards and Quality Bureau, Region X
MS 701 Arcade Plaza Bldg.
1321 - 2nd Avenue
Seattle, Washington 98101

Dear Ron,

Federal cutbacks in Medicare and Medicaid funding for survey activities require Washington state to modify it's survey program. Enclosed is a final "plan" describing changes that need to be made to handle the federal budget cuts.

The enclosed plan is consistent with those topics which were the subject of preliminary discussion between appropriate state and federal representatives. We appreciate the time and assistance you and your staff have provided in these difficult times. This coordinated effort should expedite the approval process.

Approval is critical as federal budget cuts were effective October 1, 1981. Delayed implementation will increase the amount of cuts required. State funds are not available to make up for the reduction in federal funds. In addition, certain changes will require approval by the state legislature, scheduled to meet in special session early this November. Federal approval of the enclosed plan is requested prior to the beginning of the special session on November 9, 1981. In prior discussions, you indicated such was feasible.

The enclosed plan does not include changes in the survey activity covered by the State Fire Marshal. Federal funds passed through to the Fire Marshal have been reduced. This reduction, to the degree that it may reduce Life Safety Code (LSC) inspections, remains of grave concern. We believe the reductions can be presently absorbed without changing the basic LSC survey process. Prior to any changes, you will be provided an opportunity to review and respond.

In our judgement, the restructured survey program will provide adequate and effective protections for the state's residents in nursing homes. If portions of the enclosed plan can not be approved by HHS, other cuts will have to be made. Our review and study indicates that available alternatives do not as well serve the intent of the Congress or patient interests.

The enclosed plan has been carefully developed to highlight important and necessary survey elements. It will eliminate duplicative activities and permit the allocation of resources to those homes with patient care defficiencies.

Extensive public and provider review and comment has occurred through the Department's federal budget reduction planning process. Comments received on the survey changes have been highly supportive. The changes have been approved by the Attorney General's staff.

Please express our gratitude to Region X staff for the many hours devoted to addressing federal changes and budget reductions. If you have any questions on the plan, please call Fran Moellman at 753-4719. Your expedited consideration of this plan is appreciated We will be calling to keep in touch.

Yours truly,

Conrad Thompson

Conrad Thompson
Bureau of Nursing Home Affairs

CT:sb

cc: Gerald Reilly
Bruce Ferguson
Alan Gibbs
Joe Anderson

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Proposed Modifications In Survey Program
To Manage Federal Budget Reductions

State of Washington
Department of Social and Health Services
Division of Medical Assistance
Bureau of Nursing Home Affairs
October 8, 1981

SUMMARY

The primary goal of the Survey Program in the Bureau of Nursing Home Affairs is to identify and evaluate the care and services provided to nursing home residents. Major responsibilities of the program include: surveys for annual licensure and certification of 310 long-term care facilities in Washington State; follow up to determine the status of required corrective actions; and investigations of complaints received by the Bureau on behalf of the residents in these facilities.

Surveys are conducted unannounced on at least an annual basis with one night or weekend survey every three years. Survey findings result in an overall evaluation of a provider's effectiveness in rendering safe and adequate care to residents. Since 1976, the intents of federal survey requirements have been the foundation of the survey process. The federal survey regulations were analyzed and the specific intent of each defined in relation to the health and safety needs of residents. The survey teams use guidelines and their professional judgements in determining if the intents have been met. The team is composed of a registered nurse and registered sanitarian who have had extensive training and experience in the survey process. The survey team for Institutions for the Mentally Retarded also includes a professional psychologist.

The teams are in frequent contact with the Quality Assurance and Patient Review Program staff of the Bureau to exchange monitoring information regarding the care of 29,000 nursing home residents. The Patient Review Program staff conduct initial assessments and periodic reviews of the care provided to Title XIX residents. They visit most facilities on a more frequent basis than the survey team and therefore provide information to the survey team about trends or problems with patient care in particular facilities.

A return visit (post-survey) is made to any facility that had deficiencies cited during the survey or during a complaint investigation. The purpose is to monitor corrections of deficiencies as agreed upon by the facility and the State Agency.

Investigations of complaints are also conducted unannounced and in a timely manner depending upon the seriousness of the matter and the threat to the health and safety of residents. Patient abuse and epidemiological problems as well as miscellaneous complaints are investigated by the survey team members using the survey regulations and process.

Compliance enforcement activities are initiated when corrections have not been made or when the quality of care provided is below minimum standards. These activities may result in civil fines, decertification or license revocation. Short-term agreements may be granted to facilities as a less rigorous sanction and require another visit by the survey team.

Due to current federal and state budget cuts, decision packages were prepared by DSHS to reduce costs in program administrative areas while retaining essential services. Three decision packages are directly related to the survey program:

1. Frequency of On-Site Post Survey - On-site post surveys will be discontinued except for those facilities where there is a serious deficiency which poses a potential threat to the health and safety of residents. (Refer to page 5.)

2. Certification Period - Certification will be extended for up to 3 years for facilities that have demonstrated an ability to maintain continuing compliance with the regulations. (Refer to page 7.)

3. Surveying for Paper Compliance - Federal survey regulations for SNF, ICF, and IMR which relate to internal management practices, paper compliance or which involve duplication, will no longer be reviewed per se. The intent of each regulation is defined to assure that essential health and safety requirements are maintained. (Page 10 and all attachments.)

It is estimated that implementation of these changes plus parallel changes in the state's licensure program will result in a savings of 4.1 FTE staff or $124,500 during the remainder of the state's 1981-1983 biennium.

Technical Definitions

The federal survey regulations are grouped under various Conditions of Participation. The format of the regulations and significance of the various components with respect to compliance are:

Condition - addresses each major division of institutional administration, services, and environment.

Standard - separates the condition into subdivisions.

Element - provides specifics of the standard.

The Washington State survey program staff (since 1976) review federal regulations that meet the intent of assuring health and safety needs of residents in nursing homes. The regulations most directly related to health and safety are listed as key conditions, standards, and elements. Non-compliance with key regulations frequently leads to short-term agreements or other negative actions. It always results in more intensive monitoring.

FREQUENCY OF ON-SITE POST SURVEYS

PRESENT SYSTEM

An on-site post survey is conducted following each survey to determine whether or not corrections have been made on deficiencies found at the time of the survey.

Federal regulations require that deficiencies be remedied within 60 days, with the exception of some physical plant alterations. If during the post survey, it is found that there has been no correction or if only some progress toward correction has been made, the facility provides a new plan of correction. A second post-survey may be required for follow-up.

Until January 2, 1981, post-surveys were conducted primarily on those facilities which had significant or standard level deficiencies. This was done by federal mandate to verify correction of those deficiencies which resulted in conditional agreements. The state was also encouraged to post-survey for elemental deficiencies.

As of January 1981, state requirements were in place for verification of correction of all levels of deficiencies in all facilities. If correction cannot be verified and progress toward correction is inadequate, the provider is subject to civil penalties.

PROPOSED SYSTEM

Recent federal instructions accompanying budget cuts require that post-surveys be conducted only selectively.

The Bureau will conduct on-site post-certification visits as necessary and appropriate to determine to its satisfaction whether correction of deficiencies at the standard or key element level has been accomplished.

The visits would be based on the following criteria:

Criteria	Decision for Post-Survey
No deficiencies	No post-survey
Non-key elemental deficiencies	Post-survey ten percent sample
Other factors (see below)	Post-survey as necessary
Key standard and/or key elements unmet	Post-survey 100 percent

On-site post-survey visits for other factors include: high turnover of nursing home administrative and line staff, history of poor performance, frequent changes of ownership, history of complaints including patient abuse, staff walk-outs and strikes, and finding that providers had not taken corrective action on deficiencies as identified by the ten percent sample.

Following implementation of this proposal, there would be a reduction in the amount of time necessary for on-site post-survey visits, by about 50 percent. Conducting unannounced on-site visits on a ten percent sample basis would provide an incentive for providers to make the necessary corrections. Conducting on-site visits in 100 percent of the facilities with significant deficiencies will place the emphasis where the need is the greatest.

CERTIFICATION PERIOD

PRESENT SYSTEM

Recent changes to the Social Security Act include removing the requirement for time-limited agreements for skilled nursing facilities (SNF) certified under Title XVIII. 42 CFR currently includes requirements for a maximum certification period of one year for long-term care facilities in Title XVIII and Title XIX, thus, requiring at least annual surveys.

The Bureau has recently been informed by Region X that the federal regulations will be revised to allow for longer certification periods for Title XVIII and Title XIX facilities.

A reduction in Washington State's funding allocation for Title XVIII and Title XIX for survey and certification activities, along with instructions from Region X DHHS, mandate the reduction of survey frequency. This can best be accomplished by allowing longer certification periods for facilities that have demonstrated an ability to maintain continuing compliance with the regulations.

PROPOSED SYSTEM

The Bureau proposes that certification periods be allowed up to a maximum of thirty-six months based on the following schedule:

Period of Certification	Criteria
36 Months	No health or safety deficiencies; waived requirements would not be considered as deficiencies.

Period of Certification	Criteria
24 Months	No key deficiencies, few elements not met; waived requirements would not be considered as deficiencies.
18 Months	One or two key element level deficiencies only and all standards met; waived requirements would not be considered as deficiencies.
12 Months or Less	Deficiencies at the standard and key elemental levels; waived requirements would not be considered as deficiencies. The period of certification within this category would depend on the magnitude of the deficiencies in terms of potential hazard to patients.

Other factors that will influence the frequency of surveys include high turnover of nursing home administrative and line staff, history of performance, change of ownership, history of complaints including patient abuse, staff walkouts and strikes.

It is estimated that the percentage of nursing homes with extended certification periods will be as follows:

Period of Certification	Percentage of Facilities
36 Months	5%
24 Months	30%
18 Months	30-40%
12 Months or Less	25-30%

In addition to extending the certification period, the conditional agreement provision would be eliminated. This provision allows a facility to be certified for 12 months with a condition that the certification would be automatically canceled on a specific date within the 12-month period unless the facility is found to have corrected or made substantial progress toward correcting deficiencies. The conditional agreement is recognized by providers as a "paper tiger" approach to enforcement. It has not been effective. Enforcement methods would continue through court-tested methods of decertification action.

Following implementation of this proposal, there would be a reduction in the amount of time needed for survey/certification activities. It allows the state survey agency to spend less time in facilities that are meeting requirements and an opportunity to spend additional time in those that need more attention. It also provides an incentive for providers to achieve and maintain compliance knowing that doing so will result in fewer surveys.

Extending the length of time between visits will reduce monitoring frequency. However, in the interim surveyors will be conducting complaint investigations; the Patient Review staff will be making patient assessments and reviews of the care provided to the residents receiving Title XIX Medicaid funds; and consultant staff will be assisting those providers needing help.

SURVEYING FOR PAPER COMPLIANCE

PRESENT SYSTEM

Surveys and complaint investigations are conducted using the appropriate federal and state regulations. Conditions, standards, and elements are marked as met or not met based upon the result of investigating and evaluating the facilities' ability to provide adequate care and services.

Many certification requirements identified on the federal forms relate to internal management practices, paper compliance and, in addition, many are duplicative. Surveying for these items consume resources of both facility and survey staff, whicn should be directed toward the provision and evaluation of patient care.

These requirements include provisions for monitoring administrative policies and procedures, quarterly staffing reports, and reviews of contracts and committee meeting minutes. Examples include requirements for specific kinds of medical director administrative responsibility, frequency of physician visits based on the calendar versus patient need, governing body functions, budget preparation, transfer agreements and certain committee activity requirements.

Quality of care is most appropriately surveyed by assessment, observation and interview of the patient, observation of facility services and environment, discussion with facility staff, and a review of health records.

PROPOSED SYSTEM

This state proposes that certain federal requirements no longer be specifically included in the survey of long-term care facilities. Eliminated for survey purposes would be regulations related to internal management practices, paper compliance and those which are duplicative of others. The enclosed survey report forms (HCFA 1569, HCFA 3070, HCFA 3070A, HCFA 3070B, SSA 3070C, and SSA 3070D) identify the requirements that would be deleted along with the revised shorter forms this state would use for surveying. Comments in the right hand column identify the intent of the regulations and provide the rationale for the deletions. It is inherent that the intents of all regulations on the survey report form are met when those on the shorter form are met.

Maintaining the requirements with the intents as described in the attachments will provide sufficient regulation to ensure adequate care. Eliminating the unnecessary requirements removes a burden from the facilities in having to expend staff resource in complying with them and removes a burden from the survey staff to survey for them.

This has essentially been the procedure used by Washington State since 1977. It reduced surveyor time in a facility by one day. The actual short-form version will save an additional three to four hours per survey in Washington.

It should be noted that those deleted items will still be used for consultation purposes. The complete forms are an excellent management tool. They simply need not be cited as deficiencies (monitored per se), when the purpose of survey is to evaluate the provider's effectiveness in rendering safe and adequate care to residents.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Region X
M/S 701 Arcade Plaza Building
1321 Second Avenue
Seattle WA 98101

November 4, 1981

Conrad A. Thompson, Director
Bureau of Nursing Home Affairs
Department of Social and Health Services
MS/OB-31
Olympia, Washington 98504

Dear Mr. Thompson:

This is in response to the proposals submitted to us on October 8, 1981 which would restructure the survey and certification process for long-term care facilities participating in the Medicare and Medicaid programs.

We found your proposal extremely well presented and thoughtfully conceived. We also believe that the proposals have merit for consideration at our Central Office as a preferred process for survey and certification among those modifications presently being attempted by a few states in other regions.

Therefore, we approve these proposals, which modify the frequency of post certification revisits, the length of survey intervals, and the implementation of partial certification surveys whereby the surveyor would not review certain specific facility requirements, with the following exceptions:

1. Frequency of On-Site Post Certification Revisits:

   We reserve the right to request post certification revisits for specific facilities on an as-needed basis.

2. Length of Survey Intervals:

   We reserve the right to determine survey intervals for facilities participating in the Medicare Program since sufficient funds may not be available to reimburse the State, or national criteria may be issued. The State should also be cautious in setting Medicaid facility survey intervals which may be beyond our funding capability.

3. Partial Certification Surveys:

   (a) New facilities must be surveyed against all requirements.

   (b) Surveyor "short forms" must be completed and retained in State files.

   (c) The SNF "short forms" must show response for the following items:

F 90 (Condition - Medical Direction)
F 286 (Condition - Laboratory and Radiological Services)
F 300 (Condition - Dental Service)
F 359 (Condition - Transfer Agreement)

(Note: Your annotated official survey form now appears to provide for short form response by cross references to related requirements.)

(d) The SNF report forms must allow a "met" or "not met" for F 462 and F 463 (Utilization Review) for Medicare SNF's since the Title XIX procedure does not substitute for Title XVIII procedures.

(e) For ICF/MR surveys, the procedure must be revised as follows:

(1) New survey forms have been issued and should be used in implementing this process.

(2) All facilities which are certified under an extended plan of compliance ending 7/1/82 must show response for each affected requirement.

This approval is effective immediately. Plese notify us when the proposals have been implemented. Please also furnish us a copy of implementation instructions and procedures issued to your staff. We will be designing an evaluation process to measure the effectiveness of this program. This evaluation will occur about June 1, 1982. Our approval, while not time-limited, is subject to revisions of Federal regulations and changes in national policy. However, we do not anticipate substantial policy or regulation change in the near future.

We look forward to working with you in implementing this new process. We will be in touch with you soon to agree upon ways in which we can jointly assure success of these innovative program changes.

Sincerely,

Ronald L. Hansen

Ronald L. Hansen, Director
Survey and Certification Program
Division of Health Standards and Quality

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Region X
M/S 701 Arcade Plaza Building
1321 Second Avenue
Seattle WA 98101

November 20, 1981

DIVISION OF HEALTH STANDARDS AND QUALITY
STATE LETTER NO. 101

SUBJECT: Revisions to Survey and Certification Procedures

This letter contains important information concerning survey and certification procedures.

We have learned from our Central Office that when regulations are changed, there will be no reference to long-term care cancellation clauses, time-limited agreements, or to annual certifications for providers and suppliers. While it will be a while until these regulatory changes are finalized, effective immediately we will institute a system of resurvey intervals and will no longer issue long-term care provider agreements with cancellation clauses. For Medicaid-only cases, our advice to you is to stop limiting long-term care certifications to 12 months, and stop showing cancellation clauses on certifications to the Title XIX Single State Agency, (SSA).

Resurvey Intervals:

We will not require annual resurveys or post-certification revisits (PCR) for any provider or supplier, or issue any more time-limited provider agreements. Instead, we will establish a resurvey interval. For all Medicare and Medicaid providers and suppliers, survey agencies should, for certifications sent to us or to the SSA, use block 17 of the C&T to show the month and year for any PCR and for the next resurvey. The Survey interval should not be more than 36 months. Both the PCR and resurvey dates must be based upon historical compliance patterns and anticipated funding availability for survey activities during the projected survey period. For LTC cases, block 13(a) of the C&T should show a beginning date, but does not need to show an ending date.

For Medicare facilities, we will indicate in block 28 of the C&T the dates we establish. Where this differs from your recommendation, we will first discuss the situation with you.

We are currently receiving quite a variety of certification kits from State agencies. We expect this variety to increase as some States undertake, for example, surveys aimed at covering only selected requirements, and others send kits for hospital surveys in which only the laboratory has been surveyed. A JCAH hospital certification kit must be processed within 36 months.

When less than a full survey is performed, the certification kit is to consist of the prescribed number of copies of the C&T, HCFA-2567, Crucial Data Extract and, where Life Safety Code waivers are recommended, appropriate documentation. This also means that the Request to Establish Eligibility forms and HCFA-1513's should be obtained and forwarded to us when health surveys and JCAH hospital activities are performed, but not when a laboratory-only or LSC-only survey is performed.

Adding Specialties or Services Without a Survey:

(a) A certified independent laboratory or CLIA licensee may add services without an onsite survey when the following requirements are met:

If the laboratory services to be added are similar to the existing services, i.e., fall within the approved specialties/subspecialties and use existing equipment and trained personnel, then additional supportive documentation is not necessary. However, if the laboratory is not currently approved in the specialty/subspecialty or the services require new equipment, facilities, or special trained personnel, then the laboratory must submit (1) documentation of the qualifications and experience of the person or persons who will provide the services and (2) copies of the test procedures, controls, and equipment to be used.

(b) A certified home health agency may add services when the following requirements are met:

1. The provider submits documentation of the qualifications and experience of the person or persons who will provide the services.
2. The provider submits a copy of any written contract where services are to be provided under contract.
3. The provider submits copies of policies and procedures governing the provision of that service.

We appreciate the way you are keeping in touch with us on your plans for getting the survey job done. In turn, we will continue to share with you our position on this topic.

Sincerely,

Thomas G. Wallner
Associate Regional Administrator
Division of Health Standards and Quality

DEPARTMENT OF HEALTH & HUMAN SERVICES

4 JAN 1982

Memorandum

Date DEC 29 1981

From Director
Health Standards and Quality Bureau, HCFA

Subject Scheduling Facilities for Survey in Fiscal Year 1982

To Regional Administrators
Health Care Financing Administration
Regions I - X

Section 2153 of the Omnibus Budget Reconciliation Act of 1981 repealed the statutory requirement for time-limited agreements for skilled nursing facilities (SNFs) (Comprehensive revision of Subpart S of the regulations eliminating the regulatory requirement for time-limited agreements is nearing completion). In addition, reductions in budgeted funds for onsite surveys of all Title XVIII facilities compel us to allocate the bulk of our available resources to surveys of poor and/or marginal facilities.

Earlier memoranda to the Associate Administrators for Health Standards and Quality (June 17, 1981 and September 17, 1981) outlined current national priorities for provider standards enforcement and identified key requirements (KRs) which might serve as the basis for selecting providers for surveys in the current fiscal year.

Since issuing those memoranda, we have refined the list of KRs (Attachment A). In addition, using data derived from the Medicare/Medicaid Automated Certification System (MMACS), we have applied the KRs as a screen against the compliance record of all SNFs, intermediate care facilities (ICFs), home health agencies (HHAs), clinical laboratories, and non-accredited hospitals. As a result of that screening process, we have been able to identify providers, by provider number, name, and address (Attachment B) in the following level of compliance categories:

(1) Facilities deficient in one or more Class A requirements. (Class A requirements are those requirements, which if not met, are most likely to have an immediate adverse effect on patient health and safety).

All facilities identified in this category should be surveyed during FY 82 because they have established a record of poor compliance with the program requirements.

(2) Facilities meeting all Class A requirements but deficient in one or more Class B requirements. (Class B requirements are those requirements, which if not met, are likely over time, to have an adverse effect on patient health and safety).

Page 2 - Regional Administrators
Health Care Financing Administration
Regions I - X

The decision to survey facilities in this category should be based on established national priorities, and on other available information concerning the current status of compliance with major requirements, for example, beneficiary complaints.

(3) Facilities meeting all Class A and Class B requirements.

Facilities in this category have established a record of compliance with major program requirements and, in the absence of more current adverse information, should not be surveyed in the current fiscal year. (Attachment C provides a model notice to facilities which will not be surveyed in the current fiscal year.)

We believe the lists of providers in the three levels of compliance categories will provide Regional Offices and State agencies with a rational basis for allocating available survey resources. I must emphasize that these lists are to assist you. You are not bound to follow them exactly. However, I would suggest you have a rationale for using different approaches.

If you have any questions or comments concerning the material, please contact Tony Elias, telephone number (FTS) 934-7903.

Aris T. Allen, M.D.

Attachments

cc: Associate Regional Administrators
Regions I-X

Attachment A

SKILLED NURSING FACILITIES

Conditions of Participation and Key Requirements

DATA TAG	REQUIREMENT	CLASS
F7*	Compliance with Federal, State & Local Law	A
F8	Licensure (KR)	
F15*	Governing Body and Management	B
F25	Administrator (KR)	B
F26	Qualified Administrator (KR)	C
F41	Personnel Policies and Procedures (KR)	B
F42	Responsibility for Implementing/Maintaining Policies/Procedures (KR)	C
F45	Safe and Sanitary Environment (KR)	C
F48	Staff Development (KR)	B
F49	Planning and Conducting Ongoing Program for all Personnel (KR)	C
F53	Outside Resources (KR)	B
F54	Arrangements (KR)	C
F62	Patients' Rights (KR)	B
F63	Written Policies and Procedures (KR)	C
F71	Voice Grievances (KR)	B
F73	Physical and Chemical Restraints (KR)	B
F81	Patient Care Policies (KR)	B
F83	Availability and Content (KR)	B
F90*	Medical Direction	B

[illegible]	REQURIEMENT	CLASS
F94	Coordination of Medical Care (KR)	B
F96	Liaison and Evaluation of Services (KR)	C
F101*	Physician Services	A
F105	Physician Supervision (KR)	A
F106	Physician Supervision Policy (KR)	B
F107	Planned Regimen of Care (KR)	B
F123*	Nursing Services	A
F124	Director of Nurses (KR)	A
F128	Director of Nurses - Responsibility (KR)	B
F129	Charge Nurse (KR)	A
F133	Charge Nurse - Responsibility (KR)	B
F134	24-Hour Nursing Service (KR)	A
F136	24-Hour Nursing - Proper Care (KR)	B
F169	Patient Care Plan (KR)	A
F171	Patient Care Plan - Goals and Responsibilities (KR)	B
F172	Patient Care Plan - Review and Evaluation (KR)	B
F189	Conformance with Physician Drug Orders (KR)	A
F190	Drug Orders Administered by Physician Order (KR)	B
F207*	Dietetic Services	A
F208	Staffing (KR)	A
F211	Sufficient Supportive Personnel (KR)	B
F221	Menus and Nutritional Adequacy (KR)	A
F222	Therapeutic Diets (KR)	A
F224	Planned Diets Served under Supervision/ Consultation (KR)	B

	REQUIREMENT	CLASS
F244	Sanitary Conditions (KR)	A
F246	Sanitary Conditions - Stored, Prepared (KR)	B
F249*	Specialized Rehabilitative Services	A
F254	Plan of Care (KR)	A
F255	Written Plan of Care - Physician (KR)	B
F263*	Pharmaceutical Services	A
F264	Supervision of Services (KR)	A
F268	Monthly Drug Regimen Review (KR)	B
F286*	Laboratory and Radiologic Services	A
F287	Provision of Services (KR)	A
F288	Provision of Services - Meet Sections 405.1028 and 405.1029 (KR)	B
F300*	Dental Services	B
F301	Advisory Dentist (KR)	B
F302	Dentist Participation in Staff Development (KR)	C
F308*	Social Services	B
F309	Social Service Functions (KR)	
F310	Medical, Emotional Needs Identified (KR)	
F311	Services Provided (KR)	
F324*	Patient Activities	B
F330	Patient Activities Program (KR)	
F331	Meaningful Patient Activities (KR)	
F333	Activities Promote Patient Well-being (KR)	
F335*	Medical Records	A
F344	Content (KR)	A

F346	Medical Records Content (KR)	B
F359*	Transfer Agreement	B
F366*	Physical Environment	A
K6	Life Safety From Fire (KR)	A
F371	Facilities for Physically Handicapped (KR)	A
F396	Patient Rooms and Toilet Facilities (KR)	A
F403	Facilities for Special Care (KR)	A
F407	Dining and Patient Activities Room (KR)	A
F413	Kitchen and Dietetic Services (KR)	A
F415	Properly Ventilated and Equipped (KR)	B
F420	Other Environmental Considerations (KR)	A
F421	Functional, Sanitary Environment (KR)	B
F428*	Infection Control	A
F435	Aseptic and Isolation Techniques (KR)	A
F436	Effective Written Procedures (KR)	B
F448*	Disaster Preparedness	A
F449	Disaster Plan (KR)	A
F450	Disaster Plan in Operation	B
F457	Staff Training and Drills (KR)	A
F458	Trained Personnel (KR)	B
F462*	Utilization Review	C
F490	Extended Stay Review (KR)	
F491	Periodic Review (KR)	
F499	Further Stay Not Medically Necessary (KR)	

DATA TAG	REQUIREMENT	CLASS
F500	Decisionmaking Process	
F527	Discharge Planning (KR)	
F528	Operation of Organized Program	

* - Condition of Participation
KR = Key Requirement

Attachment A

INTERMEDIATE CARE FACILITIES

Standards and Key Requirements

DATA TAG	STANDARDS/KEY REQUIREMENTS	CLASS
T13*	Disclosure of Ownership	C
T20*	Transfer Agreement	B
*	Administrative Management	B
T25	Staffing (KR)	
T55	Disaster Prepardness (KR)	
T63*	Administrator	C
T64*	Resident Services Director	C
T65*	Arrangements for Services	C
T66	Institutional Services (KR)	
T72	Medical and Remedial Services (KR)	
T73*	Rehabilitative Services	B
T74	Plan of Care (KR)	
T80	Provision of Services (KR)	
T82*	Social Services	B
T84	Plan of Care (KR)	
T89	Activities Plan (KR)	
T94*	Physician Services	A
T95*	Health Services	A
T103	Health Care Plan (KR)	
T104	Review Plan as Needed (at least quarterly) (KR)	
T105	Nursing Service (KR)	

DATA TAG	REQUIREMENT	CLASS
*	Dietetic Services	A
T106	Meals (KR)	
T112	Therapuetic Diets (KR)	
T115	Menu Planning & Nutritional Adequacy (KR)	
T117	Sanitary Conditions (KR)	
*	Drugs and Biologicals	A
T123	Conformance with Drug Order (KR)	
T129	Medication Review (KR)	
T132*	Resident Record System	B
T135	Content (KR)	
T138	Copies of Initial and Periodic Exams (KR)	
T139	Assessments, Goals of Each Plan of Care (KR)	
T140	Discharge Summaries (KR)	
T141	Overall Plan (for the individual) (KR)	
T143	Treatments and Services Rendered (KR)	
T144	Medications Administered (KR)	
K6	Life Safety Code	A
*	Environment and Sanitation	A
T152	Environment (KR)	
T153	Favorable Environment (KR)	
T160	Linen (KR)	
T165	Isolation (KR)	
T166	Dayroom and Dining Area (KR)	
T189	Policies Define Use of Chemical/Physical Restraints (KR)	

* - Standards
KR = Key Requirements

HOME HEALTH AGENCY Attachment A

Conditions of Participation and Key Requirements

DATA TAG	REQUIREMENT	CLASS
G6*	Federal, State & Local	A
G7*	Organization, Services, Administration	A
G8	Services Provided (KR)	
G10	Governing Body (KR)	
G11	Administrator (KR)	
G12	Supervising Physician or R.N. (KR)	
G15	Coordination of Patient Services (KR)	
G26*	Group of Professional Personnel	B
G28*	Acceptance of Patients, Plan of Treatment, Medical Supervision	A
G30	Plan of Treatment (KR)	
G32	Conformance with Physician Orders (KR)	
G33*	Skilled Nursing Service	A
G34	Duties of Registered Nurse (KR)	
G36*	Therapy Service	A
G43*	Medical Services	B
G46*	Home Health Aide Services	A
G48	Supervision (KR)	
G49*	Clinical Records	A
G51	Protection of Records (KR)	
G52*	Evaluation	B
G54	Clinical Record Review (KR)	

*- Conditions of Participation
KR = Key Requirement

Attachment A

LABORATORIES

Key Requirements for Specialties and Subspecialties

Microbiology

E96	Chemical & Biological Solutions (KR)
E114	Quality and Requirements are Met (KR)
E34	Proficiency Testing (KR)

Parasitology

E122	Quality Control Requirements for Parasitology are Met (KR)
E37	Proficiency Testing (KR)

Virology

E126	Quality Control Requirements are Met (KR)
E38	Proficiency Testing (KR)

Syphilis Serology

E148	Quality Control Requirements are Met (KR)
E40	Proficiency Testing (KR)

Non-Syphilis Serology

E163	Quality Control Requirements are Met (KR)
E41	Proficiency Testing (KR)

Chemistry

E193	Quality Control Requirements are Met (KR)
E42	Proficiency Testing (KR)

Urinalysis

E198	Quality Control Requirements are Met (KR)
E45	Proficiency Testing (KR)

Immunohematology

E208	Quality Control Requirements are Met (KR)
E46	Proficiency Testing (KR)

Hematology

E252	Quality Control Requirements are Met (KR)
E50	Proficiency Testing (KR)

Exfoliative Cytology

E272	Quality Control Requirements are Met (KR)
E52	Proficiency Testing (KR)

Histopathology

E285	Quality Control Requirements are Met (KR)

Oral Pathology

E286	Quality Control Requirements are Met (KR)

Radiobioassay

E294	Quality Control Requirements are Met (KR)

KR = Key Requirement

Attachment A

HOSPITALS

Conditions of Participation and Key Requirements

DATA TAG	REQUIREMENT	CLASS
A6*	Compliance with State & Local Law	B
A9*	Governing Body	B
A16	Institutional Planning (KR)	C
A21*	Physical Environment	A
A26*	Medical Staff	B
A47*	Nursing Department	A
A73*	Dietary Department	A
A91*	Medical Record Department	B
A115*	Pharmacy or Drug Room	A
A126*	Laboratories	A
A153*	Radiology	A
A162*	Medical Library	C
A164	Surgery (KR)	A
A180	Anesthesia (KR)................................	A
A185	Rehabilitation (KR)............................	B
A190*	Outpatient Department	B
A195*	Emergency Service or Department	A

* - Condition of Participation
KR = Key Requirement

Attachment B

Skilled Nursing Facilities

These listings for SNFs are divided into three categories according to their level of compliance with the Class A and Class B requirements specified in Attachment A. The categories are as follows:

1) SNFs deficient in one or more Class A requirements.

2) SNFs meeting Class A requirements and deficient in one or more Class B requirements.

3) SNFs meeting all Class A and Class B requirements.

Each of the reports displays the SNFs in provider number sequence and separates them by State within Region.

Outlined below is a brief explanation of the data items included in each of the listings.

1) Provider Number - Self-explanatory.

2) Provider Name and Address -Self-explanatory.

3) Last Survey Date - The most current provider record on the MMACS data base as of October 27, 1981.

4) Class A and Class B Deficiencies - Indicates the number of regulations designated in Attachment A as Class A and Class B requirements and reported in MMACS as deficiencies.

5) Certified Beds - The number of total certified beds recorded on the Certification and Transmittal, HCFA-1539.

Since the compliance records considered in the name and address listings are based on the information entered and processed in MMACS as of October 27, 1981, more recent survey data entered after that date will not be reflected in the reports. The Rapid Data Retrieval System (RADARS), however, does contain more recent provider survey information. If you wish to utilize RADARS to access the more current data, ask the MMACS Coordinator in your Region to contact the staff in the Data Management Branch for specific instructions.

Attachment C

Notification to Selected Providers of the Extension of Existing Provider Agreements

Section 2153 of the Omnibus Budget Reconciliation Act of 1981 repealed time-limited agreements for skilled nursing facilities. In so doing, the basis for regulations issued pursuant to that provision has been eliminated. Major Revisions in Subpart S of the Federal regulations will establish new procedures for determining the length of provider agreements and the frequency of surveys.

Based on your history of compliance with Major Medicare/Medicaid program requirements, your provider agreement is extended through September 30, 1982.

Although your facility is not scheduled for a survey by SA staff through September 30, 1982, you may be selected as part of a sample of facilities which may be surveyed by Federal surveyors or may be surveyed on the basis of a complaint.

DEPARTMENT OF HEALTH & HUMAN SERVICES **Health Care Financing Administration**

Region III
P.O. Box 7760, 3535 Market St
Philadelphia, PA 19101

HSQ-R3 (18)

January 11, 1982

H. Arnold Muller, M.D.
Secretary, Department of Health
Health and Welfare Building
Harrisburg, Pennsylvania 17120

Dear Dr. Muller:

On December 15, 1981, President Reagan signed the third continuing resolution of fiscal year 1982 (P.L. 97-85). This resolution provided funding through March 31, 1982, but also decreased the Medicare State Survey and certification budgets by 16.62%.

Consequently we are reducing your Medicare budget for fiscal year 1982 to $695,660 (attached is your revised budget). In addition because the department has limited the quarterly awards to 25% of the reduced budget we have had to revise your 640T's (see attached) for the first and second quarters of FY 82.

We realize that this decrease will present additional problems in accomplishing the workload for Medicare. However we are requesting that you continue to approach the workload as was approved in our original FY 82 letter (dated September 8, 1981) for the second quarter until we can determine what changes in budgets will occur in the third and fourth quarters. The Medicaid budget has not been affected by this reduction.

If you have any questions concerning these changes please let me know.

Sincerely yours,

Gerald L. Szucs

Gerald Szucs, Ph.D.
Associate Regional Administrator
Health Standards and Quality Bureau

cc:
C. Fiseon
J. Jasiewski
E. Bryant
G. Szucs
R. Marsicano
A. Grodecki
T. Hook
J. Clark
B. Brennan ✓

DEPARTMENT OF HEALTH & HUMAN SERVICES

MA F3

Health Care Financing
Administration

Region III
P.O. Box 7760, 3535 Market St
Philadelphia, PA 19101

APR 22 1982

H. Arnold Muller, M.D.
Secretary of Health
Pennsylvania Department of Health
Health and Welfare Building
Harrisburg, Pennsylvania 17120

Dear Dr. Muller:

Once again we are approaching the budget season. Although we have not received budget guidance for fiscal year 1983, preliminary indications are that Congress will in all probability fund the state survey and certification activity at fiscal year 1982 levels.

Based on our experience in 1982, we have formulated criteria for each state survey agency to follow in the submission of the FY 83 Medicare budget requests. These criteria pertain to program emphasis and funding limitations based on national and regional priorities that should be strictly adhered to. Since there is no indication of decreased dollars in Medicaid, you should prepare your Medicaid certification budget as usual, however, keep in mind that if the single state agency decides to go to a less often than annual survey cycle, the budget should reflect this reduction. If the state Medicaid agency decides to prioritize its workload, you should submit the lists categorizing the priorities.

Submit your FY 83 Medicaid budget in accordance with Section 1902(a)(2) of the Social Security Act. For planning purposes federal matching share for compensation, travel and training costs for the Medicaid survey and certification program is 75 per cent. All cost categories other than compensation, training and travel will continue to be reimbursable at 50 per cent. Please refer to Health Standards and Quality Bureau, Standards and Certification State Letter No. 263 for additional guidance.

Your Medicare certification budget request should reflect the target funding limitation of $695,660. This is what you received in FY 82. Using the same formula as in FY 82, we estimated this funding limitation based on priority workload, survey times, and historical costs. The regional office and the states agreed to this criteria in FY 82. If any changes occur in our funding limitation for FY 83, we will inform you immediately.

Concerning the survey activities for FY 83 we have established a priority approach to the Medicare workload. Attached to this letter are the instructions which are to be followed in preparing your budget. Essentially, the process establishes priorities by categories of providers and suppliers to be surveyed and further defines within specific categories the mechanisms for ranking specific providers and suppliers. For your information, the following is an outline of the priorities in FY 83:

1. Initials (all providers and suppliers, and changes of ownership, if necessary).
2. All category 1 facilities (resurveys in the following order)
    a. Skilled Nursing Facilities

   b. Hospitals (non accredited General Hospitals, accredited and non accredited Psychiatric Hospitals)

   c. Laboratories (Includes CLIA and Independent Labs)

   d. ESRDs

   e. Home Health Agencies

3. Complaint surveys (all providers and suppliers).

4. All providers and suppliers not surveyed at least once in the last two federal fiscal years (1981 and 1982).

5. Validations of accredited hospitals.

6. All category 2 facilities (resurveys in the following order)

   a. Skilled Nursing Facilities

   b. Hospitals (non accredited General Hospitals, accredited and non accredited Psychiatric Hospitals)

   c. Laboratories (Includes CLIA and Independent Labs)

   d. ESRDs

   e. Home Health Agencies

7. Resurveys of Home Health Agencies (initial surveys in FY 82).

8. All facilities not surveyed in federal fiscal year 1982 due a resurvey.

9. All category 3 facilities (resurveys in priority order as state defines).

Except as provided above, funding is not available for resurveys of JCAH general hospitals, outpatient physical therapy/speech therapy, Rural Health Clinics, portable X-ray facilities and independent practicing physical therapists.

You will note in the list of priorities that numbers 2, 6 and 9 categorize participating providers. In order to rank providers as categories 1, 2 and 3, please refer to the guidance in attachment A, II, Section B and D. Using this guidance, you will be able to establish the ranking in each of these priorities.

Once you have ranked your providers, you will then be able to determine which of the priorities listed are obtainable based on the budget limit indicated in this letter. Keep in mind you should allocate the money according to the priorities in the listed sequence. However, we are requesting at a minimum that your budget address priorities 1 through 5. In addition, we are also asking you to define and cost-out separately as part of your proposal, the priorities in 6 through 9.

The submission of the budget for both Medicare and Medicaid must include the information requested in exhibits 2 and 3. Exhibit 2 is a request for the number of providers/suppliers which you will survey in FY 83 and the estimated costs for the surveys by priority and provider category. Exhibit 3 asks you to identify by name, provider number and category all facilities/suppliers to be resurveyed during each quarter of FY 83. The regional office will negotiate and approve the provider lists submitted.

The State Operations Manual, Part IV Administration and Financial Management, is the technical guide to be used in the preparation of the state's fiscal year 1983 budget submittal. Section 4010 ff, "The Planning Process," should be carefully reviewed and followed in conjunction with this letter. Federal Management Circular (FMC 74-4) cost principles applicable to grants and contracts with state and local governments provide principles for determining the allowable costs of programs administered by state governments under grants from and contracts with the federal government.

Enclosed are copies of the forms to be used in the budget submission. They include State Survey Agency Budget Request Health Insurance Benefits Program (Title XVIII) (Form SSA-1465), State Agency Budget List of Positions Health Insurance Program (Form SSA-1465A), State Agency Schedule for Equipment Purchases Health Insurance Benefits Program (Form SSA-1466) and State Survey Agency Budget Request-Long Term Care Facility Workload. The activity plan must describe in detail how the state agency will accomplish the survey workload. It must adequately document and clearly support those costs reflected in the budget request.

In preparing budget projections, you should keep in mind that, pursuant to Title 42 CFR 446.175, the cost of activities performed by the state survey agency for the purpose of the state licensure program or any other state program must be borne by the state. The survey agency must maintain records to identify the costs of these activities.

In conclusion, in preparing your budget projection, you should obtain input from any other state department that participates either directly or indirectly in the survey and certification activity, such as the state fire authority, single state agency, etc. Your budget presentation must include an indication that affected state departments have been made aware of the budget plan and, to the degree possible, have indicated their concurrence. A copy of subcontract(s) that have been entered into with regard to the survey and certification activity should accompany your budget submittal.

We expect to receive your fiscal year 1983 budget requests in the regional office no later than June 30, 1982. If your budget requests are incomplete by June 30, 1982, i.e., lack formal state approval, justification for line item amounts, etc., please forward what has been completed to date as an informational copy. It is important that this due date be met to allow us sufficient time to evaluate your budget requests fairly.

If you have any questions about the budget process for fiscal year 1983 or should you need further clarification of those items presented, please call Timothy Hock at (215)596-6951).

Sincerely yours,

Gerald P. Szucs, Ph.D.
Associate Regional Administrator
Health Standards and Quality

[COMMITTEE STAFF NOTE: Attachments reflecting costs by category of provider survey have been deleted for brevity.]

JOHN SPELLMAN
Governor

ALAN J. GIBBS
Secretary

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Olympia, Washington 98504

RECEIVED
MAY 5 1982
DSHS - Bureau of Nursing Home Affairs

April 29, 1982

TO: Conrad Thompson, Director
Bureau of Rursing Home Affairs

THRU: John Gerth, Manager
Survey Program

FROM: Don Gatterman, Manager
Southwest Survey Zone

SUBJECT: FACILITIES WHOSE LAST TWO SURVEYS SHOW A CHANGE FOR THE WORSE

In response to your request to identify facilities whose last two surveys have shown a change for the worse; 5 facilities were researched. The following results indicate the numbers of standards and elements unmet in each survey and the suspected reason for the change.

They are as follows:

	SURVEY 1 YR. AGO DATE SURVEYED			LAST SURVEY DATE SURVEYED			COMMENT
FACILITY	TOTAL STDS. UNMET	KEY STDS. UNMET	ELEM. UNMET	TOTAL STDS. UNMET	KEY STDS. UNMET	ELEM. UNMET	REASON FOR INCREASED NON-COMPLIANCE
[redacted]	3/17-19/81 0		9	2/19/82 2	2	9	This facility has a new DNS and charge nurse which had not been properly oriented at the time of the survey. The administrator should have been on top of this.
[redacted]	2/27/81 0		18	1/22/82 1	0	3	This facility basically had two major problems; 1) was rodent infestation in the food storage area and 2) was a new DNS trying to change long established procedures, and some details just fell through the cracks.
[redacted]	4/21/81 4		17	3/2-3/82 5	3	10 (3 key)	"The administrator is folksy and laid-back, and does not check on his staff." The DNS is too friendly with her staff and is not on top of patient care problems. The charge nurse had also fallen down in her duties. "Supervision is sloppy throughout." Staffing is stable

	SURVEY 1 YR. AGO DATE SURVEYED			LAST SURVEY DATE SURVEYED			COMMENT
FACILITY	TOTAL STDS. UNMET	KEY STDS. UNMET	ELEM. UNMET	TOTAL STDS. UNMET	KEY STDS. UNMET	ELEM. UNMET	REASON FOR INCREASED NON-COMPLIANCE
[redacted]	3/19/81			2/24/82			
	0		13	3	0	7	Increased deficiencies at this facility are due to poor management on the part of the administrator, and nursing staff taking over for the DNS, in her absence for maternity leave. Staffing is otherwise stable at this facility
[redacted]	4/24/81			3/3/82			
	0		4	2	0	6	Deficiencies noted could be due in part to a new A.I.T. and a new health services supervisor and possibly a lack of close supervision by the preceptor.

The comments noted above adhere very closely to references made by the surveyors in each of these areas. One surveyor indicated that: "It is easy to blame management, however, it all stems back to a lack of pride, and doing for these other human beings, (the patients) what they (facility staff) would like to have done for themselves."

I trust that the foregoing information satisfies your request for data in this area, if not please let me know.

JOHN SPELLMAN
Governor

ALAN J. GIBBS
Secretary

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES

MEMORANDUM

RECEIVED
APR 30 1982
DSHS Bureau of
Nursing Home Affairs

TO Conrad Thompson, Director
Bureau of Nursing Home Affairs
Through: John Gerth, Manager
Survey Program
FROM Mary Z. Crosby, Manager MZC
Northwest Survey Zone

DATE April 29, 1982

SUBJECT: NEW SURVEY PROCESS

This memo is in response to your request at our (Zone Manager's) meeting held with you on April 15, 1982. You asked that each Zone Manager select one specific case and point out how a facility's patient care had worsened from it's prior survey.

Facility: [redacted]
Beds = 62

April 4, 1981 PRIOR SURVEY	February 8, 1982 THIS YEAR'S SURVEY
NURSE SURVEYOR: "NO" DEFICIENCIES	THIS YEAR"S SURVEY HAS BY THE SAME NURSE USING THE SAME SURVEY PROCEEDURES: - Five Standards Not Met, two of which were Key Standards -F124 Director of Nursing Service -F129 Charge Nurse -*F134 24-hour Nursing (Key Standard) -F177 Supervision of Patient Nutrition -*F435 Aseptic Techniques (Key Standard - Three Key Elements Not Met: -*F135 24-hour Nursing -*F175 Rehab. Nursing -*F436 Aseptic Techniques - Six non Key Elements Not Met

SANITARIAN SURVEYOR:	SURVEY COMPLETED BY THE SAME SANITARIAN USING THE SAME, SURVEY PROCEEDURES
	- Two Standards Not met, one of which was Key Standard - *F435 Aseptic Technique (Key) - F444 Linen
- Two elemental deficiencies - F418 and F419 Maintenance of Building and Equipment	- Two Key Elements Not Met: - *F419 Maintenance of Building Equipment - *F436 Aseptic Technique *(duplicate of nurses)

A total of six standards were not met of which two were Key.
A total of four Key Elements were not met
A total of eight Elements other than Key were not met

Based only on the 1981 nurse's section of the survey, using our new Washington State criteria for length of certification, this facility would have received a thirty-six month certification.

Based on the entire survey which consisted of only two deficiencies statements, this facility would have received an eighteen month survey using the present criteria for determining length of certification.

COMPARISON SUMMARY OF ABOVE DEFICIENCIES

1981 SURVEY	1982 SURVEY (11 months later
- 6 bed to chair residents	-13 bed to chair residents
-4 total feed patients	-9 total feed patients
- 10 patients need assistance with eating	-19 patients need assistance with eating
- 6 residents on self feeding program	-"NO" residents on self feeding programs
- "NO" skin breakdown	-10 residents with skin breakdown
- good bladder training programs	-"no: bladder program to decrease incontinence (18 incontinennt patients)
- good bowel programs, very little laxatives used	-no bowel progrsm to encourage independent bowl function (9 patients dependent on suppositories.
- care plans good - follow through on correcting problems	-problems were noted on care plans but little was done to follow through and correct identified problems

	- weight losses -decreased appetite -skin breakdown -decreased fluid levels -need for change of position and proper body alignment (6 patients seen in poor body alignment)
- medication accuatly given	- lack of supervision to assure medications and treatments were given as ordered
-initial assessments very good	-assessments in areas of potential independence not done
-NO decubiti	-10 patients with decubiti
-Hot water temperature for laundry sanitation too low	-Hot water temperature for laundry again too low for proper laundry sanitation. In addition washing methods deteriorated in that facility staff was mixing heavy and light soiled linen

This facility does seem to have made a trend toward heavier care patients than before, but seems to be unable to cope with the problem presented by the increasing care required for the heavier care resident. A six month certification was given to this provider following the 1982 survey. Had we done the 1982 survey six months later than it was done as, we would have under the new criteria, the facility could possibly have deteriorated in care enough to have required a decertification.

It should also be noted that:

-Two weeks later on February 22, 1982 a complaint investigation was made by the same survey nurse. The complaint was partially valid and Standard F 59 Notification of Changes in Patient status was found not to be met. (not pickedup on the random records reviewed at the time of 1982 survey)

may have found it

OTHER COMMENTS RE NEW SURVEY PROCESS PRO AND CON:

Con Two other facilities would have been given 18 month certifications after their last survey if based on the new criteria for certification. These two will be given six month certifications based on surveys done a year later. The two facilities are:

[redacted]

Con a three year certification [redacted] has written to their legislator.

Pro Providers have stated they are hoping surveyors will have more time with less surveys to do, to be able to come into their facilities and give them guidance between surveys. With less surveys to do, this will be a posibility during slack times.

⊃ Consultant role

Con One nurse surveyor stated that there seems to be a trend toward heavier care residents in her area. The opinion is that residents are not being placed in nursing home until absolutely necessary due to the economy and are a great deal more debilitated at the time of admission. Many nursing homes do not have staff that is really knowledgable in the problems of the aged and especially the more debilitated resident. Without continued guidance given to the providers adequate care could decline rapidly as has been evidencec by her last ten surveys completed since January 11, 1982. Six of these ten facilities had standard level deficiencies.

MZC:jh

cc: John Gerth

JOHN SPELLMAN
Governor

ALAN J. GIBBS
Secretary

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES

MEMORANDUM

O Conrad Thompson

Through: John Gerth

ROM Mike Jessup

DATE May 24, 1982

SUBJECT: LENGTH OF CERTIFICATION

You previously requested that I send you information regarding the lengthening of certification periods beyond 12 months. Over the course of the past several months I, and the surveyors of the Eastern Zone, have been in contact with many industry people who have expressed concern over the lengthening of the time between surveys. These people all feel that the more time that passes between surveys, the more likely the facility will be found to have problems at the next full survey. Stated another way, the problems that come up between surveys will be allowed to get much worse if the survey is delayed by several months to three years. The following individuals have expressed this concern:

--Pearl Belt, D.N.S. at Hillcrest Nursing Home, Grandview
--Vivian Johnson, Administrator, Pend Oreille Pines
--Betty Selde, D.N.S., Smith Nursing Home
--Duane Johnson, Administrator, Park Manor
--Pat Locati, D.N.S., Park Manor
--Albert Bell, Administrator, Booker Convalescent Annex
--James Clay, owner of 3 Regency Care Centers and Mt. Adams Care Center
--Harvey Johnson, Administrator, Spokane Valley Good Samaritan Center
--Dorothy Lange, Administrator, Hillcrest Convalescent Center, Pasco
--Harvey Young, M.D., physician and former Medical Director for many
  nursing homes, member of Nursing Home Advisory Council

A couple of examples will show the problems with long certifications. BNHA Survey staff surveyed [redacted] in January/February, 1981 and cited several problems, but found all standards met. If our current criteria had been in effect at the time of that survey, the provider would have been eligible for an 18 month certification and would not have been resurveyed until August or September 1982. We instead issued a 12 month certification and surveyed [redacted] [redacted] in early January, 1982. We found, at that time, that 6 of the elemental citations noted in February, 1981 had worsened to the point where the corresponding standard was found to be not met. In addition, a 7th standard was also not met. These were in areas such as Rehabilitative nursing, Patient care planning, Infection control, 24 hour nursing services, Charge nurse, Director of nursing services, and Staff development. The situation was found to be very poor--one can imagine how much worse the finding might have been if we had not conducted our survey until September, 1982, 8 months later! Obviously, there are certainly cases where lengthy certification periods will work to the detriment of patient health and safety.

[redacted] and [redacted] [redacted] only elemental deficiencies last year to not met this year. These are only a couple of examples of this happening.

In my opinion, we are dealing with a somewhat unstable situation. If we were dealing with a system, or a machine, it would be possible to "fine tune" it to perfection and expect it to stay that way for long periods of time. In fact, we are dealing with human beings, with all their attendant frailties and shortcomings. The provision of adequate care in compliance with applicable regulations can break down gradually or precipitously based on the knowledge, attitude, understanding, experience, and ability of the facility staff. This is also greatly affected by type and quality of leadership and supervision they receive. It was mentioned to me that even the facility with a "good" D.N.S. and Administrator who have several years of experience could conceivably "get into trouble" with a long certification period. It is obvious that the operation with a new and/or inexperienced D.N.S. or Administrator is at great risk of spiralling into the depths of non-compliance without timely monitoring by BNHA staff. We cannot hope or expect that the filing of complaints will be our "early warning" system to monitor provider slippage. By the time the situation gets to the point of complaint filing, we are far past the early warning stage. The old adage about an ounce of prevention being worth a pound of cure is certainly applicable in this situation.

cc: John Gerth
Mary Crosby
Don Gatterman

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing
Administration

f.a.c.

Refer to DFO

Region V
175 West Jackson Boulevard
Chicago, IL 60604

June 1982

CHICAGO REGIONAL STATE LETTER NO. 7-82

SUBJECT: Funding for Survey and Certification Activities
-INFORMATIONAL

Some States in Region V have requested guidance relating to the current requirement for time-limited provider agreements with nursing homes under the Medicaid program. Since the Omnibus Reconciliation Act of 1981 removed the one year limitation for provider agreements with Skilled Nursing Facilities participating in the Medicare program, the requirements for annual surveys under Medicaid are inconsistent with those under Medicare. Particular concern was expressed about potential financial disallowances if facilities were not surveyed annually.

We believe that the attached memorandum from the HCFA Associate Administrator for Operations, dated June 1, 1982, contains HCFA's position in this matter. If the State follows the guidance contained in that memorandum, financial disallowances should not occur.

Philip Nathanson
Regional Administrator

Attachment

cc: Director, State Health Department

Originating Component - Division of Financial Operations

Acu 2 5 02

DEPARTMENT OF HEALTH & HUMAN SERVICES
Financing Administration

Memorandum

[JUN 17 1982]

Date JUN 1: 82

From George A. Thompson
Associate Administrator for Operations Thompson

Subject Funding for Survey and Certification Activities — Your Memorandum of May 10, 1982

To Philip Nathanson, Regional Administrator
Region V, HCFA

Section 2153 of the Omnibus Reconciliation Act of 1981 repealed the mandate that agreements with Skilled Nursing Facilities (SNFs) be limited in duration to 12 months. In the Report issued by the Committee on the Budget, attendant to the Omnibus Reconciliation Act of 1980, Congress expressed the view that all SNFs and intermediate care facilities (ICFs) do not require a full annual survey. The clear intent of Congress in this area was further affirmed by survey budget reductions in FY 1981 and 1982. Thus, although there have been no formal regulatory changes, the clear intent of Congress supersedes existing regulatory requirements for annual surveys and time limited agreements.

When the funding of State activities was sharply curtailed in 1981 and carried over in 1982 the kinds of problems being experienced by your States were anticipated. It was apparent that States would need the flexibility to adjust the number and frequency of surveys if they were to stay within their budget allocations. As early as May 1981, Thomas G. Morford, Director, Office of Standards and Certification, HSQB, developed an interim national policy which has been reaffirmed several times over the past year.

Essentially, States were advised:

1. To prioritize their survey activities to ensure the compliance history of all facilities would be reviewed to determine the need for an onsite survey;

2. To ensure that when it was decided, based on compliance history, not to survey a SNF or ICF, the agreement with that facility would be extended; and

3. To ensure that funds would be set aside to survey new facilities and to followup on complaints.

Recently, we published a Notice of Proposed Rulemaking which proposed numerous changes in the survey and certification process, including flexible survey cycles and elimination of time limited agreements and automatic cancellation clauses. However, until such time that regulations can be finalized, the interim policy to extend agreements with long-term care facilities based on past compliance remains in effect. I believe that this policy is a sound management approach which recognizes fiscal realities and clearly meets the intent of Congress.

We will not approve the disallowance of Federal Financial Participation payments to any State for providers not surveyed if the State can document that decisions not to survey were based on a rational plan which sets priorities in accordance with the historical compliance of facilities.

cc: Regional Administrators, HCFA,
Regions I - IV, and VI - X
Associate Regional Administrators,
OHSQ, Regions I - X

OLYMPIA J. SNOWE
2ND DISTRICT, MAINE

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June 3, 1982

The Honorable Richard S. Schweiker
Secretary of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Secretary Schweiker:

We are writing to commend your action on behalf of the health, safety, and human rights of nursing home residents, and to express our deepest concern that enforcement of these basic protections be stringently maintained. The assurance of quality care demands both high standards and strict enforcement; high standards alone will mean little without the means to enforce them.

An impassioned public outcry reached our offices last January following reports of draft proposals to significantly weaken the conditions of participation for skilled nursing homes. The people of this country are deeply concerned about the quality of care in nursing homes and expressed their indignation that the federal government would act to weaken these basic protections. We appreciate your responsiveness to the widespread public concern and are relieved to know that current minimal safeguards for nursing homes will not be relaxed.

We now ask for your commitment to ensuring the enforcement of these standards. We believe the federal government must continue to operate an effective enforcement system that ensures minimum standards of care and decency. Only the federal government has the capacity, will, and legitimacy to insure the uniform protection of nursing home residents across the country.

Therefore, we are deeply concerned over the major shift in the federal government's enforcement policies with respect to nursing home inspections evidenced in the regulations issued on Monday, May 24. Three areas are of particular concern:

> First, changes in the survey and certification process that would permit less than annual surveys of nursing homes and verification by phone or mail that deficiences have been corrected. We agree that homes with a poor history of compliance require increased attention. However, those nursing homes that comply with minimal standards still require regular surveillance to assure that a change in personnel, ownership, or operation does not cause a deterioration in the quality of care. Marginally compliant homes could develop serious problems if left unchecked for a longer period of time.
>
> Second, authorization of deemed status for certification by a private, non-governmental, non-regulatory body, specifically the Joint Commission on Accreditation of Hospitals (JCAH). The JCAH has expressed that it is not and does not wish to be an enforcement agent. Further, the JCAH has neither significant consumer representation nor the public accountability

Secretary Schweiker
Page Two
June 3, 1982

to assume this role. We, therefore, believe that the authorization of deemed status for JCAH would represent a serious abdication of responsibility on the part of the federal government.

And third, the reduction of federal funds used to survey nursing homes. States have already experienced funding cutbacks in a number of areas and are now being required to make extremely difficult choices on how to allocate scarce resources. The assurance that nursing homes are complying with minimal standards of health and safety is one area that cannot afford to be reduced.

One additional point deserves consideration. Fifty-seven percent of nursing home revenues come from the federal government. The inspection process serves an auditing function as well as assuring a certain standard of care. It enables the government to determine what they are buying with their money. Cutting back funds and inspection requirements may well prove penny-wise and pound-foolish. The Administration has strongly favored cutting down on the waste of tax dollars, however, a reduction in the tax dollars spent on inspections may well result in an increase in tax dollars expended in poor quality nursing home care.

Your commitment to maintaining the health and safety standards for nursing home residents represents an important reaffirmation of continuing federal responsibility in this area. It is essential that this not become an empty promise in the wake of a federal retreat from enforcement responsibility. We urge you to reconsider any action which would have this effect.

Thank you for your serious attention to our concerns. We look forward to your response.

Sincerely,

Olympia Snowe
Olympia J. Snowe

Stephen Solarz

Peter W. Rodino
Peter Rodino

James L. Oberstar
James Oberstar

Bill Clinger
Bill Clinger

David F. Emery
David Emery

Shirley Chisholm

Richard Ottinger

Edwin Forsythe

Bill Lehman
William Lehman

Barbara Mikulski

Bob Edgar
Bob Edgar

Claude Pepper

John Porter

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Edward Roybal

Dante Fascell

Baltasar Corrada

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Mario Biaggi

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Robert Matsui

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Jonathan Bingham

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Ron Wyden

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Dan Glickman

Don Edwards
Don Edwards

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JOHN C. ROTHER, STAFF DIRECTOR AND CHIEF COUNSEL
E. BENTLEY LIPSCOMB, MINORITY STAFF DIRECTOR

United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, D.C. 20510

June 15, 1982

The Honorable Richard S. Schweicker
Secretary of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Mr. Secretary:

On February 3, many of us wrote you about our concerns with the Department's proposed revisions of nursing home regulations governing conditions of participation. We were pleased by your decision reaffirming the Federal commitment to protect the health, safety, and human rights of nursing home residents. However, regulations for the nursing home inspection program issued May 27 raise serious new questions about the continued strength of this Federal commitment. In our view, the Federal role in assuring quality nursing home care demands more than just establishing minimum standards of care and decency. It also requires an effective nursing home inspection program to ensure that these standards of care are enforced.

We commend you for recognizing the need to reform our current inspection program, with stricter monitoring of those nursing homes with compliance problems. However, we believe that the May 27 regulations, as proposed, weaken federal and state enforcement capabilities and do not meet your objectives. To avoid this result, we propose the following changes in the regulations.

1) The regulations would authorize deemed status for certification by the Joint Commission on Accreditation of Hospitals (JCAH), a private body. The JCAH has long stated that it cannot be an enforcement agent, nor can it assume the responsibility of public accountability. Since JCAH policy is to keep survey results confidential, neither the Health Care Financing Administration nor state governments will have the information necessary to maintain their responsibility to enforce standards of care. In addition, the requirement that facilities post JCAH recommendations is insufficient to respond to the public and federal and state need to obtain adequate information about the quality of care in a nursing home. Disclosure requirements for surveys must be explicit, and survey results must be available to federal and state governments and the public if this proposal is implemented.

2) The regulations would eliminate mandatory annual surveys with the exception of ICF/MRs. A two year survey cycle for all other nursing homes with an acceptable compliance history would permit better targeting of limited resources on facilities with compliance problems. However, the proposed regulations are unclear as to how this is to be achieved. Problems serious enough to warrant more frequent surveys are not defined, nor is it clear how facilities with compliance problems would be identified. Although the proposed regulations do not state who would have the authority to determine the need for more frequent surveys, we assume that HCFA and state governments would bear this responsibility. Yet providing deemed status

for JCAH certification, as proposed, raises questions as to whether they will have the necessary information about a facility's compliance history to exercise their responsibility. In addition, the proposed regulations make no allowances for changes in ownership or other significant changes which could alter a facility's performance. The proposed regulations should clarify the above areas of concern to make certain that facilities with compliance problems will indeed be more strictly monitored.

3) The regulations would eliminate mandatory 90-day on-site re-surveys to provide more flexible follow-up times and require on-site visits only if there is no other way to verify correction of deficiencies. While we agree that the 90-day limit is arbitrary, placing no time limit on re-surveys provides no assurance that deficiencies will be monitored or corrected in any reasonable time frame. Enforcement and monitoring are further weakened by allowing verification of deficiency corrections by telephone or mail, leaving no mechanism for the responsible agency to assure that these corrections have been made. These proposals, combined with the proposed elimination of automatic cancellation of the facility's provider agreement if deficiencies are not corrected on time, remove essential tools for a strong nursing home inspection program. We ask that defined maximum periods for re-surveys, on-site visits, and the cancellation clause provision be maintained except for minor technical violations. These exceptions should be well-defined in the regulations.

We propose these changes in the spirit of mutual concern for the health and safety of nursing home residents. We believe that these modifications are absolutely necessary to protect patient well-being and assure public accountability. At the same time, we feel they will still allow a more efficient and effective nursing home inspection program without over-extending federal and state enforcement capabilities.

We look forward to receiving your response to our requests. We also ask that you provide the Committee with a copy of the Department's recent evaluation of JCAH nursing home standards and a copy of your assessment of what will constitute a life threatening and/or serious deficiency for purposes of proposed survey and certification targeting to nursing homes with compliance problems. Thank you for your consideration.

Sincerely,

John Heinz
JOHN HEINZ
Chairman

Lawton Chiles
LAWTON CHILES
Ranking Minority Member

Dave Durenberger
DAVID DURENBERGER
United States Senator

Quentin Burdick
QUENTIN N. BURDICK
United States Senator

NANCY LANDON KASSEBAUM
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LARRY PRESSLER
United States Senator

JOHN SPELLMAN
Governor

ALAN J. GIBBS
Secretary

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Olympia, Washington 98504
MS OB-31

June 16, 1982

Ronald L. Hansen, Director
Survey and Certification Program
Division of Health Standards and Quality
HCFA, Region X, DHHS
Arcade Plaza Building, MS 701
1321 Second Avenue
Seattle, Washington 98101

Dear Mr. Hansen:

Your letter dated May 18, 1982 informs the Bureau that we are at risk in conducting further Medicare survey and certification activities due to federal budget reductions and the uncertainty of receiving additional Medicare funding.

As you are aware, there have been numerous budget reductions in the Title XVIII program, resulting in a 36 percent reduction in Medicare funding for federal fiscal year 1982. Since the beginning of the current federal fiscal year, the Bureau has accomplished the following changes in the Survey Program to react to the decreased funding level:

(1) Reduced total survey staff by four full-time surveyors and a supervisor.

(2) Implemented a new survey process involving a major change in survey philosophy and documentation. Obtained necessary federal waivers well in advance of other states. The majority of this work was accomplished at state expense.

(3) Implemented criteria for certification periods of up to three years and retroactively applied them to surveys performed within three months preceding the waiver approval.

(4) Maintained quality of survey work, with no dilution of fire safety requirements.

Extended survey periods are expected to produce additional cost savings. Reductions in activity is less during FY 1982 because it is necessary to survey most of the providers in order to determine an appropriate period of certification. To not survey would mean the issuance of blind certifications, based on previous survey results which may not by representative of the current situation.

It is not advisable or in the interest of patient care to extend certification periods for homes that have not been resurveyed for many months. Experience from state and federal validation surveys evidences that dated surveys do not necessarily represent current findings. In fact, one home that would have received a 24 month certification under approved criteria was found to have three standards out three months later.

To blindly extend certifications in dual Title XVIII/Title XIX nursing homes without a survey takes on added significance when you consider that legislation has been in effect in Washington State during the last year which permits a 20 percent shift between cost centers with the exclusion of property. Until cost reports and other data have been analyzed, or the homes resurveyed, there is no way of knowing the impact of this shifting on the delivery of patient care.

There has been a nine percent increase since December 1, 1981 in the number of providers certified for the Medicare program, despite the absence of any provisions for funding additional Title XVIII survey activity. Ninety-two of the ninety-eight Medicare homes are also certified for Medicaid. The Bureau cannot accomplish a Medicaid survey in these homes without incurring a Medicare cost, given the one-third allocation formula. The state recently recommended and requested that the state be allowed to perform a Medicaid survey only and share this time 50 percent to Medicaid and 50 percent to state licensure. It is my understanding that this option is not acceptable by the Regional office.

We are left no choice but to discontinue Medicare only related survey and certification activities until after September 30, 1982, except those of an emergency nature, including complaints. The two Medicare facilities that have not been surveyed are:

Group Health Hospital and,

United General Hospital.

You have jurisdiction and do certify Title XVIII homes. Is it appropriate that you notify these homes before November 1, 1982 as to the status of their certification? If the federal government is insistent upon extending the certification periods of homes which have not been surveyed for a substantial period of time, then it is only appropriate that the federal government be responsible for the consequences of such extensions.

It is regretful that we must temporarily discontinue this Medicare activity. I remain hopeful that sufficient funds will be made available to ensure the health and safety of residents in Title XVIII homes. State staff remain available to discuss all reasonable suggestions that would accomplish this end.

Certification of 21 dual-certified homes due for survey prior to November 1, 1982 includes Medicaid. Given the one-third allocation formula and the nonavailability of Medicare funds, the state cannot survey these facilities without adverse fiscal consequence. The state will continue to survey those homes as scheduled, as it is clearly in the interest of patient care, and the states new waivered survey process. I am requesting that every effort be made to provide additional matching funds.

I have enclosed for your convenience information regarding changes in the delivery of patient care as referenced on page 2.

Please do not hesitate to contact me if I may answer any questions or provide further information.

Yours truly,

Conrad Thompson

Conrad Thompson, Director
Bureau of Nursing Home Affairs

CT:sb

Enclosure: Memo from D. Gatterman through J. Gerth to Conrad Thompson, dated 4/29/82.

cc: Joseph Anderson
Tom Wallner
Jerry Thompson
Charles Murphy
Gerald Reilly
John Gerth

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JOHN C. ROTHER, STAFF DIRECTOR AND CHIEF COUNSEL
E. BENTLEY LIPSCOMB, MINORITY STAFF DIRECTOR

United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, D.C. 20510

August 4, 1982

The Honorable Richard S. Schweiker
Secretary of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Mr. Secretary:

As you know, the Senate Special Committee on Aging has been deeply committed throughout its history to assuring the delivery of quality care to our Nation's nursing home residents. In light of this commitment, we have reviewed the Department's May 27 proposed rule changes for the nursing home inspection program with particular care.

We agree with your stated objectives for reforming the current survey and certification system: "making it more flexible and easier to administer, while retaining the enforcement capabilities necessary to ensure the health and safety of Medicare and Medicaid beneficiaries." There is a need to shift the system's focus from paperwork compliance to quality patient care. However, we do not believe that your proposed rules meet your stated objectives. Nor do they meet the objectives of the Vice President's Task Force on Regulatory Relief which originally targeted these rules for reform. We believe these proposals run counter to your assurance in March that the safety of nursing home residents will not be imperiled. Rather than streamlining and strengthening federal regulations, it is our conclusion that basic federal protections of nursing home residents have been removed by your May 27 proposals.

On June 15, we wrote you to express our serious concerns with the Department's proposed rules and to suggest specific modifications. On July 15, we held a hearing to further examine the potential impact of these proposed regulations. Testimony given during the hearing by the Administration failed to address our initial concerns, nor has any response to our letter been forthcoming. In fact, our hearing actually raised additional reservations about the wisdom of these proposals.

Witnesses at the July 15 hearing included representatives of a State attorney general's office, the fifty-six state and territorial health officers, the western region's state licensing officials, and over forty national and one hundred state and local aging, consumer, and professional groups. These witnesses were unanimous in opposition to your proposed rules, stating that the new regulations would add to duplicative paperwork, remove essential enforcement tools from an already overburdened system, and shift the certification role to a private body with no public accountability or enforcement authority.

Representatives from the nursing home industry, although basically supportive of the proposed rules, joined the above-mentioned witnesses and Members of this Committee in recognizing that these rules need extensive revision. But we would point out that the testimony received did not offer only criticism of the proposed regulations. State officials, patient advocates, and the nursing home industry all suggested alternative means to achieve a streamlined survey system that focuses on quality patient care without removing those federal safeguards which assure high standards of care.

Based on our evaluation of the proposed regulations and testimony received at the hearing, we request that the proposed rules as they effect nursing homes be withdrawn. While the Committee initially believed that modifications might address some serious problems, the criticisms of these proposals and need for revisions are substantial enough to require resubmission. Clearly, minor changes in the proposed rules will not suffice.

The Members of this Committee are convinced that the Department, the nursing home industry, patient advocates, State officials and Congress share compatible goals. We are pleased to transmit to you the transcript of our hearing. We believe that the criticisms, suggested modifications and proposed alternatives presented during the hearing, as well as comments you have received previously, offer a path for constructive reform. We understand that developing new alternatives may result in a delay in the regulatory process. However, time cannot be an issue when the protection of our vulnerable nursing home population is at stake.

The Committee looks forward to receiving your response at the earliest possible opportunity. We offer you our assistance in developing alternative survey and certification proposals at any time.

Sincerely,

JOHN HEINZ
Chairman

LAWTON CHILES
Ranking Minority Member

PETE DOMENICI
United States Senator

JOHN GLENN
United States Senator

CHARLES PERCY
United States Senator

DAVID PRYOR
United States Senator

WILLIAM COHEN
United States Senator

BILL BRADLEY
United States Senator

LARRY PRESSLER
United States Senator

CHRISTOPHER DODD
United States Senator

The Honorable Richard S. Schweiker
Page 3

Chuck Grassley
CHARLES GRASSLEY
United States Senator

John Melcher
JOHN MELCHER
United States Senator

DAVID DURENBERGER
United States Senator

Quentin Burdick
QUENTIN BURDICK
United States Senator

Nancy Kassebaum
NANCY KASSEBAUM
United States Senator

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date NOV 9 1982

From Acting Director
Health Standards and Quality Bureau

Subject Continuing Resolution Funding for Medicare State Certification Activities

To HCFA Regional Administrators
Regions I-X

On October 2, 1982, President Reagan signed a Continuing Resolution (P.L. 97-276), providing the Federal Government with funding through December 17, 1982. Following much negotiation with the Department, the funding target provided during the Continuing Resolution period for Medicare State Certification activities is $5.4 million, which provides funds to inspect all Skilled Nursing Facilities (SNF) requiring certification/recertification during this period together with resources to maintain about the same less than annual survey frequency as 1982 for all other facilities. Specifically, the Assistant Secretary for Management and Budget has directed the following survey activities under the Continuing Resolution:

> SNFs at the 100 percent rate provided by Section 135 of the Tax Equity Act; for all other facilities, up to 22 percent of the number of surveys realized in FY 1982.

Attached is a table reflecting States' Continuing Resolution allocations, established from FY 1983 Associate Regional Administrator approved State's budgets which have been proportionately increased to meet the $5.4 million operating level provided by the Department. Attached are State HHS 640-T forms for your region. Excluding SNF resources, State allocations can be shifted within the total regional allocation to incorporate specific program/facility priorities. Please advise when such changes occur so Departmental Federal Assistance Financing System records can be adjusted accordingly.

States should be advised immediately of the increased FY 1983 program level of funds available. Workload estimates for FY 1983 may need to be renegotiated within available funds and facility priorities.

Please contact me if you need further information concerning the Continuing Resolution funding level.

Thomas D. [illegible] for
Philip Nathanson

Attachments

FY 1983
Medicare State Certification
Continuing Resolution Funding
10/1/82 - 12/17/82

ALL REGIONS		5,408,278
REGION I	TOTAL	389,703
	CONNECTICUT	141,324
	MAINE	25,924
	MASSACHUSETTS	158,425
	NEW HAMPSHIRE	17,204
	RHODE ISLAND	29,259
	VERMONT	17,567
REGION II	TOTAL	612,133
	NEW JERSEY	144,997
	NEW YORK	444,087
	PUERTO RICO	19,886
	VIRGIN ISLANDS	3,163
REGION III	TOTAL	477,939
	DELAWARE	12,189
	DIST. OF COLUMBIA	14,592
	MARYLAND	76,925
	PENNSYLVANIA	275,912
	VIRGINIA	51,245
	WEST VIRGINIA	47,076
REGION IV	TOTAL	807,589
	ALABAMA	114,766
	FLORIDA	203,156
	GEORGIA	109,091
	KENTUCKY	77,149
	MISSISSIPPI	66,532
	NORTH CAROLINA	98,799
	SOUTH CAROLINA	55,018
	TENNESSEE	83,078
REGION V	TOTAL	797,194
	ILLINOIS	159,989
	INDIANA	87,985
	MICHIGAN	191,952
	MINNESOTA	77,302
	OHIO	183,961
	WISCONSIN	96,005
REGION VI	TOTAL	566,853
	ARKANSAS	71,093
	LOUISIANA	57,764
	NEW MEXICO	36,044
	OKLAHOMA	78,222
	TEXAS	323,730
REGION VII	TOTAL	280,401
	IOWA	70,100
	KANSAS	56,080
	MISSOURI	98,141
	NEBRASKA	56,080
REGION VIII	TOTAL	302,288
	COLORADO	74,275
	MONTANA	68,483
	NORTH DAKOTA	55,270
	SOUTH DAKOTA	44,684
	UTAH	39,719
	WYOMING	19,857
REGION IX	TOTAL	910,482
	AMERICAN SAMOA	—
	ARIZONA	73,248
	CALIFORNIA	766,012
	GUAM	—
	HAWAII	30,689
	NEVADA	40,533
REGION X	TOTAL	263,696
	ALASKA	28,350
	IDAHO	29,909
	OREGON	91,579
	WASHINGTON	113,358
	FOREIGN	

FORM CO-2830 (11-71)

Memorandum

Date EC 8 1982 [DEC 8 1982]

From Margaret VanAmringe, Acting Director
Office of Standards and Certification

Subject Variability of Deficiency Findings

To Associate Regional Administrator
Division of Health Standards and Quality
Regions I - X

The Division of Program Analysis and Training has conducted a study of the variation of deficiency findings among Regions and States. This study was conducted in order to identify areas of variation and to begin to establish explanations for these variations. The data used for this study was obtained from MMACS and reflects information which was current as of March 31, 1982.

Please examine the printout and review the analysis which accompanies it. We would like your comments and we solicit your suggestions for further analysis in this area.

If you have any questions regarding this material, please call Steve Balcerzak FTS 934-3217.

Attachment

DEC 1982
RECEIVED
DHSQ/HCFA
SEATTLE

[COMMITTEE STAFF NOTE: Some attachments were omitted from the copy of this memorandum which was supplied to the Committee by HCFA.]

Variability of Deficiencies Among Regions and States.

I. Introduction

MMACS data which was current for the period ending March 31, 1981 through March 31, 1982 was examined to determine what differences existed among Regions and among States in reporting deficiencies for skilled nursing facilities and intermediate care facilities. Deficiency levels were examined for all skilled facilities, 18 and 19 skilled facilities, 19 only skilled facilities as well as intermediate care facilities in each State and Region. Deficiency levels were specified for the total number of deficiencies in each facility type and the total number of A key requirements in each facility type. Levels for total deficiencies ranged from 0 to greater than 25, while levels for A key requirements ranged from 0 to greater than 5. The number of facilities in each State or Region in each specified level is expressed in percentages to show the relative distribution of facilities. Tables are organized by facility type. Each set of tables for total deficiencies is followed by a set of tables for A key requirements.

II. Overall Variability Among States and Regions

The first two tables depict the percentages for total skilled nursing facilities. The variability among Regions is depicted in Table 1. In Table 1, Regions II, VIII and IX have 20 or more deficiencies in at least 50% of their facilities. At the same time, Regions III, IV and V have less than 25% of their facilities in this category. Table 2 depicts the variability which exists among States. For example, some States such as Connecticut, New York, Mississippi and California have at least 20 or more deficiencies in 50% of their facilities. Other States such as New Hampshire, Tennessee, Michigan and Oregon have only 11% of their facilities in this category. The percentage of facilities without deficiencies also demonstrates significant variation. South Carolina and Minnesota have no deficiencies in at least 10% of their facilities while other States such as Oklahoma, Colorado and West Virginia have no facilities without deficiencies.

The pattern of variability continues within Regions. For example, Mississippi has no facilities without deficiencies while South Carolina has 13.5% of its facilities without deficiencies. At the same time, Mississippi has 25 or more deficiencies in almost half of its facilities while South Carolina has 10.4% of its facilities in this category. This same pattern is repeated within Region VI for Arkansas and Texas and for other States in other Regions.

[illegible] from [illegible]

1. Can facilities in States and Regions be that different? Are facilities in one State so inferior or so superior to facilities in other States?

2. Do more deficiencies mean worse facilities? Do large numbers of deficiencies in elements mean large numbers of deficiencies in standards and conditions or are standards and conditions deficient at the same rate in all States no matter how many deficiencies are discovered at the element level?

3. Is this variability the result of the unreliability of surveyors as a group? Does surveyor judgment on the definition of non-compliance with any specific regulation vary so greatly that there is very little consensus?

4. Is this variability a result of differing survey agency approaches? Are most deficiencies discovered most of the time but then unreported, unrecorded, overreported, discounted, consulted on, corrected onsite, considered too small too often by some and never too small by others? Are all of the above determined by State agency written policy or a result of ingrained unwritten procedure?

III. A Key Requirements

The number and percentages of facilities deficient in A key requirements were evaluated in order to determine the method of utilization of national key requirements and the possible impact on survey cycles.

Tables 3 and 4 represent the variability among Regions and States for these deficiency findings.

Overall, 64% of all skilled nursing facilities have no A key deficiencies. The variability discussed in Section I continues for A key requirements among Regions, across States and among States in the same Regions. Regions I, II, VIII and IX have no more than 60% of their facilities without A key deficiencies while Regions III, V and X have no deficiencies in 75% or more of their facilities. This pattern of variation continues among States. Of particular interest are facilities in Wisconsin at 95%, Pennsylvania at 88% and Oregon at 89% without A key deficiencies. At the same time other States reflect greater numbers of facilities with deficient A key requirements. The contrast in this category is also reflected in States like Massachusetts at 51% and Arkansas at 30%. States within Regions also demonstrate variability in the number of facilities without A key deficiencies. South Dakota has only 31% of its facilities without deficient A key requirements while North Dakota has 68%. Hawaii has 92% while Nevada has 30%.

[illegible], data from 1980 was compared to 1982 key deficiency data to discover if Central Office identification of some requirements as key requirements caused surveyors or survey agencies to consider them differently.

Changes between 1980 and 1982 do not indicate that this occurred. Thirty-seven States reflected decreases in the number of facilities with deficient A key requirements. Thirteen States demonstrated increases in the number of facilities with deficient A key requirements, however, nine of these reflected increases averaging less than 2.2% while only four of these States reflected significant increases greater than 10%. Therefore, as a group States do not appear to have imputed added importance to these key requirements, and consequently, they have not been surveyed with increased scrutiny. What is clear is that most States continued to discover deficiencies in these requirements at somewhat lower rates than 1980. States whose survey processes were particularly adept at discovering deficient A key requirements continued to do so. States whose processes did not discover them continued in the same manner.

IV. Evaluating State Performance

When Tables 2 and 4 are evaluated together, the intensity of the survey process within each State can be determined. This is especially true for States with a high percentage of facilities with more than 25 deficiencies. For example, 59% of Connecticut's skilled nursing facilities have more than 25 deficiencies but 66% of its facilities have no A key deficiencies. Sixty-one percent of California's facilities have more than 20 deficiencies yet 55% of its facilities have no A key deficiencies.

These findings indicate that there is a greater likelihood to discover many deficiencies but lesser likelihood to discover crucial deficiencies in these States. Both of these States follow a fairly stringent pattern in citing deficiencies in all requirements.

However, since Connecticut does not cite deficiencies in A key requirements it can be stated that either its process does not evaluate key areas as readily as California or that its facilities provide higher quality of care in key areas than California facilities. At the same time Kansas demonstrated an increase in deficient A key requirements between 1980 and 1982. This change is a result of an apparent change in survey method or quality of its facilities. If the confusion regarding utilization of A key requirements is more completely understood the deficiency levels should remain as they presently are only if they reflect the true level of quality in each State's facilities.

Utilization of Key Requirements raises two issues:

1. Should key requirements be applied with equal emphasis and scrutiny in all States or should States make use of them only to shorten surveys and increase survey cycles when confronted with survey agency budget shortfalls?

2. If State agency budgets are determined on the basis of the number of surveys performed each year and State agencies determine one or two year survey cycles on the basis of deficiencies in A key requirements, then some State agency budgets could be significantly affected. States like Wisconsin could receive a 50% budget cut since most of its facilities could be surveyed every other year. New York might receive a 25% budget cut since only one half of its facilities could be surveyed every other year.

Finally, nine States that have combined Inspection of Care (IoC) with the survey process were also evaluated to determine if there was a pattern of greater intensity. These States are Arkansas, Maine, Massachusetts, Missouri, New York, Tennessee, Texas, Virginia and Wisconsin. A pattern of increased intensity was not evident and it cannot be stated that this combination does or does not embellish the survey process when these States are considered as a total group. Discovering States with approximately similar IoC/survey combinations might yield more specific information.

V. Variability According to Facility Type

Differentiation does occur within Regions and within States according to facility type. Regions I and V have more 19 Only facilities without deficiencies than 18/19 facilities. At the same time, 19 Only facilities are more likely to have 25 or more deficiencies in four Regions. These are Regions I, III, V, and VI. In key deficiencies, only Regions V and VII are less likely to discover deficient A key requirements in 19 Only facilities than in 18/19 facilities. This indicates there are more deficient findings in 19 Only facilities in Regions V and VII but they are not crucial. For the remaining eight Regions it can be stated that 19 Only facilities generally provide poorer quality services to their patients as evidenced by their more crucial deficiencies when compared to 18/19 facilities.

Within these Regions, States show similar patterns. For example, Connecticut finds more 18/19 facilities with more than 25 deficiencies yet it has a higher percentage of 18/19 facilities without key deficiencies. Mississippi finds more deficiencies and more key deficiencies in 18/19 facilities. California finds more deficiencies and more key deficiencies in 19 Only facilities. Finally, Illinois finds more 19 Only facilities than 18/19 facilities without deficiencies. At the same time, Illinois' surveyors discover more 19 Only facilities with higher numbers of deficiencies. However, as evidenced by key requirement data, this increase is not due to difficulties in crucial areas.

Most Regions show a changing pattern of deficiency levels per facility when intermediate care facilities are compared to skilled nursing facilities. For example, Region IX has only 55% of its skilled facilities without key deficiencies while it has 88.4% of its intermediate facilities without key deficiencies. Overall, deficiencies in this Region show a distinct pattern. Both 19 only and 18/19 facilities have many deficiencies. Many of these deficiencies are crucial key deficiencies. However, few intermediate care facilities have many deficiencies and these deficiencies are not likely to be A key requirement deficiencies. This is duplicated in Region II to a lesser degree.

Region VI surveyors demonstrate a greater likelihood of discovering a large number of deficiencies in skilled facilities of both types. However, these surveyors discover a smaller number of deficiencies in intermediate care facilities, but these deficiencies are more likely to be deficient A key requirements. That is, 61% of its skilled facilities do not have key requirement deficiencies but only 30% of its intermediate facilities are without key deficiencies. This indicates that even though the intemediate care facilities in Region VI have fewer deficiencies, these deficiencies are more crucial deficiencies. Finally, Region IV shows minimal differentiation between facilities. Surveyors in this Region do not change their survey method or method of documenting non-compliance because of the types of patients cared for in different facility types.

Generally, eight out of ten Regions have a greater percentage of ICFs without deficiencies when compared to skilled facilities. Only Regions VI and VII do not. Five Regions reflect a greater likelihood of discovering deficient A key requirements in ICFs rather than skilled nursing facilities. Some of the differences in deficiency levels are substantial and, therefore, underscore a very different approach to facilities because of their classification. For instance, while surveyors may note every deficiency in skilled facilities, no matter how small, surveyors in this same State may be following different procedures when surveying intermediate care facilities.

Questions of survey procedure and the actual level of quality as measured through grouped data from Federal monitoring surveys must be examined before more valid conclusions can be drawn. Data from monitoring surveys in each State can be examined by comparing Federal surveyor findings to State surveyor findings. If Federal surveyor findings differ significantly from State findings, the survey process and State Agency philosophy must be questioned. Changes in process and philosophy can be effected by identifying and then examining each difference in survey findings. The purpose of this examination is to discover if the difference is due to misinterpretation of the requirement, a survey method which does not correctly evaluate the requirement or a philosophy which has too little or too much emphasis on the requirement.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date January 18, 1983

From Director
Health Standards and Quality Bureau

Subject Revised FY 1983 Regional Allocations for Medicare State Certification

To HCFA Regional Administrators
Regions I-X

On December 21, 1982, President Reagan signed a Continuing Appropriation (P.L. 97-377) providing the Federal Government with funding through September 30, 1983. The annual funding rate provided by the Congress is $32,300,000 for Medicare State Certification. These funds provide support to inspect all nursing homes together with resources to inspect at least 50 percent of non long term care facilities.

Below is a table reflecting revised FY 1983 regional Medicare allocations which provides resources to accomplish required workloads. These amounts take into consideration regional comments pertaining to earlier "draft" allocations. Regional allocations are based primarily on facility counts, as reported by the regions, in the most recent MMACS master file (11/82). In order to compute these allocations, we used as a guide an average unit cost of $3,200 which was applied to the number of SNFs in each region. This would provide funding to allow a three person survey team to inspect a facility for three days (consistent with SOM guidelines) together with associated costs for followup, consultation, report writing, etc. Funds for non long term care facilities assume at least 50 percent coverage of such facilities at an average unit cost of $2,200 and provides funding for required onsite inspections and other associated costs. Amounts provided support the survey coverage as prescribed by the Secretary.

Regional Allocations - Title XVIII

Region		Amount
I		$ 1,883,200
II		3,022,500
III		2,708,000
IV		4,846,400
V		5,671,800
VI		2,790,800
VII		1,353,500
VIII		1,396,000
IX		5,184,200
X		1,143,600
	Total	$30,000,000

To provide for necessary program improvements, the central office has set aside $2,300,000 for basic and specialized training for surveyors and the procurement of an improved data system and allow each State to tie into the Medicare and Medicaid Automatic Certification System. More specific guidance pertaining to training will be provided later, including course offerings, locations and dates to assist in your development of a regional State surveyor training plan. Set-aside funds will be added to regional allocations for transfer to States after analysis of these initiatives is completed and estimates for regional implementation is determined. The set-aside funds for other identified purposes will be allocated to relevant Regions as individual States' requirements are determined.

You should immediately notify States of the increased FY 1983 program levels for Medicare survey activities and modify budget approvals to accomodate the available funds and facility survey coverage outlined in this memorandum.

To assure that States receive immediate financial relief, Central Office has prepared HHS 640T award forms for the second quarter which will be provided to DFAFS for payment. Awards have been proportionately increased from previously authorized budget approvals to coincide with the Regional percentage increase in revised allocations. These awards will be subsequently adjusted to revised budget approvals provided to Central Office prior to February 1.

Please contact me, if further information is required concerning revised regional allocations.

Philip Nathanson

Attachments

cc:
HSQ Associate Regional Administrators
Regions I-X

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Marcia

Memorandum

PA 83
Certification

U.S. GOV'T - HCFA -

Date JAN 27 1983 [JAN 27 1983]

From Director
Health Standards and Quality Bureau

Subject Clarification of Certification Issues—Your Memorandum of January 7, 1983

To Lawrence W. Osborn, M.D.
Associate Regional Administrator
Division of Health Standards and Quality
Region I

During the last quarter of 1981, we issued memoranda addressing the reduction in survey activities, the scheduling of surveys during the 1982 fiscal year, and the rationale for implementing flexible survey cycles on an interim basis. The major thrust of the memoranda was that Congress had expressed its intent that annual surveys were unnecessary for all facilities by repealing the statutory basis for time-limited agreements (TLAs), and by passing an appropriation for the State Certification Program that would not support annual surveys for all facilities. Accordingly, we suggested a methodology for prioritizing and allocating survey resources and authorized the selective extension of existing provider agreements.

Since the May 27, 1982 publication of proposed Subpart S changes, Congressional commentary, the imposition of a moratorium on the proposed rules, and the passage of a larger appropriation is indicative of a change in Congressional intent from that described earlier. In light of these factors, and because funding is now at a level to support issuing 12 month agreements and conducting annual surveys of all long-term care providers, it is encumbent on us to move toward stricter compliance with all the regulatory provisions, especially Subpart S. The same course would necessarily follow for Title XIX facilities.

We appreciate the difficult logistical problems your States will encounter in gearing up for full implementation. A liberal phase-in period would be expected under the circumstances.

Philip Nathanson

cc:
ARA's Regions II - X ✓

Talk Margaret 2/23/83
don't implement at this point in time
Some point in time may have to
[illegible]

Tab C

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date FEB - 3 1983

Clarence J Ellis Jr

From Margaret VanAmringe, Acting Director
Office of Survey and Certification

Subject Revised FY 1983 Regional Allocations for Medicaid State Certification

To HCFA Regional Administrators
Regions I-X

The current Continuing Appropriation (P.L. 97-377) provides the Medicaid State Certification program with $40,847,000 through September 30, 1983. This level of funding provides resources to inspect all long term care facilities to comply with current requirements as provided for in CFR Title 42 Subpart S.

Below is a table reflecting revised FY 1983 regional allocations, basis for which is an across the board increase of 28.4 percent over the current allocation.

Regional Allocations - Title XIX

Region	Amount
I	$ 3,580,700
II	3,352,900
III	3,434,600
IV	5,393,600
V	7,998,200
VI	6,276,400
VII	2,613,300
VIII	1,973,800
IX	4,723,500
X	1,500,000
Total	$40,847,000

States will be reimbursed for expenditures claimed and for which State matching funds are available. In most cases, the State licensure unit conducts inspections for Medicare and Medicaid programs. The Federal allocation process is intended to assist this unit in the effective use of resources available for survey activity and provide for improved fiscal management within this organization and the State title XIX agency.

As a reminder, States are expected to pay their share of survey costs with respect to licensing requirements. The attached Departmental Grant Appeals Board Decision (No. 373 dated December 30, 1982) supports the negotiated "fair share" methodology we have been using with States.

You are requested to provide State allocations to Central Office no later than February 18, 1983. Please contact Charles Lawhorn, HSQB Budget Officer on FTS 934-7032 if further information or clarification is required.

Attachment

cc:
HSQ Associate Regional Administrators
Regions I-X

[COMMITTEE STAFF NOTE: HCFA's Region III office conducted the following study of the effect of survey and certification budget cuts upon quality of care in Pennsylvania nursing homes, in December 1982 and January 1983.]

U.S. GOV'T - HCFA - III

March 28, 1983

NOTE TO FILE

SUBJECT: Life Safety Code Study

Per Dr. Szucs' instructions from Mr. Bryant, he (Mr. Bryant) released the Life Safety Code Study on buck slip to central office and we can now send copy to Pennsylvania for action.

Roseann Marsicano

U.S. GOV'T - HCFA - III

Refer to: HSQ-R3(18)

[FM:] Regional Administrator
Philadelphia Regional Office

[RE:] Life Safety Code Study

[TO:] Administrator

As discussed during your recent visit to the Philadelphia Regional Office, attached is the Life Safety Code report you requested.

Everett S. Bryant

Attachment

cc:
Bryant
Szucs
Marsicano
Van Wieren
File
REading File ✓

marsicano:lmm 3/4/83

EXECUTIVE SUMMARY

HEALTH CARE FINANCING ADMINISTRATION
DIVISION OF HEALTH STANDARDS AND QUALITY
REGION III
LIFE SAFETY CODE VALIDATION PROJECT
FACILITIES IN FULL COMPLIANCE

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During the budget reductions which occurred in 1981 and 1982, the regional office became increasingly concerned over the safety aspects in nursing homes relative to Life Safety Code compliance. In December 1982 and January 1983, a field study was undertaken to examine facilities which were exempted from life safety code survey at the time of the most recent recertification cycle by virtue of their having been found in full compliance at the time of the previous life safety code survey. The two primary objectives of this project were to assess facilities not surveyed for more than one year to determine if they had maintained a reasonable level of fire safety compliance and to assess the adequacy of the new HCFA-2786C Fire Safety Survey Report short form.

The State of Pennsylvania was chosen for this study because it was most affected by economic cutbacks, and consequently had not performed annual life safety code surveys in fiscal year 1982 on any facilities found in full compliance in fiscal year 1981. From a field of 269 skilled nursing facilities meeting that description, a random sample of 30 facilities was chosen for inclusion in this study. Joint federal/state survey teams surveyed 21 of the 30 facilities, with the state alone surveying the remainder. The surveyors performed a full survey using the short form survey document and an addendum of 10 safety elements determined in advance by the state and regional fire authorities to be critical elements not covered by the short form.

This study demonstrated that a clear majority of facilities previously found in full compliance did not maintain full compliance. Only 10% of the sample were found to be in full compliance, with 90% of the facilities having anywhere from minor deficiencies to major life threatening violations. This study also demonstrates that the short life safety code survey form was not an effective tool in monitoring life safety code compliance. Based on the surveys, 76.7% of the sample had deficiencies in elements that were not included on the short form.

The study also identified three facilities previously thought to be in full compliance to have major, life-threatening deficiencies. The study should have resulted in all facilities being in substantial compliance. Therefore, finding three facilities with major, life-threatening deficiencies indicates that less than full annual surveys may be an undesirable risk.

Based on our findings, we recommend that facilities be surveyed on an annual basis and that the full life safety survey document be used.

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METHODOLOGY

Our review of the region indicated that the Commonwealth of Pennsylvania was the state in Region III most deeply affected by budget cuts for survey activities. As a result, it adopted the policy of exempting from survey for a period of at least two years those facilities previously found in full compliance. Accordingly, we focused the study on Pennsylvania facilities. A Medicare/Medicaid Automated Certification System-Rapid Data Retrieval System (MMACS-RADARS) report was generated which identified a universe of 269 skilled nursing facilities in Pennsylvania which were without current life safety code survey. Using random sampling techniques, an initial field of 30 facilities was selected for inclusion in the project. (See Attachment #1 for list of facilities.)

Upon discussion of the initial sample with the Pennsylvania Division of Safety Inspections, it was discovered that nine of these facilities had been recently surveyed by the Division. As there was no discernible advantage to resurveying those facilities, it was determined that the state surveys would be utilized as part of the survey sample, subject to analysis as discussed later in this report.

The other 21 facilities were divided between two teams of surveyors. Each team consisted of one surveyor from the Pennsylvania Division of Safety Inspections and one surveyor from HCFA. The two teams surveyed the first two facilities together as a means of enhancing uniformity of approach. All surveys were conducted unannounced.

The survey instrument utilized was a modified Fire Safety Survey Report - Short Form (HCFA-2786C 8-82). The HCFA-2786C was renumbered for comparison purposes to have the same K-identification tag for deficiencies as the full 2786 (HCFA-2786 11/74). The short form was analyzed by the Director of the Division of Safety Inspections, a Regional Operations for Facilities Engineering and Construction (ROFEC) representative and a DHSQ representative to determine elements of fire safety which were not included on the short form, but which, in their opinion, would constitute critical deficiencies if they were found to occur. These items were covered in an addendum to the short form (Attachment #2).

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The second facility surveyed by all four surveyors as one team proved to be one of the three facilities with major life safety deficiencies discussed in Attachment #4. An assessment of items found led surveyors to adjust their method so that all information required as part of a full survey would be gathered, with the short form and addendum serving as the survey document. Additional deficiencies beyond the short form and addendum were noted under "Other items to be noted" on the addendum.

The surveyors evaluated whether deficiencies were likely to have existed at the time of the last survey and were missed, or whether they were deficiencies which had come about since the last survey. There is, to be sure, a margin of error in this assessment, but consistent team composition and approach helped to keep the error rate to a minimum.

ANALYSIS OF DATA

Each of the survey report forms for the 21 facilities surveyed by federal/state teams were reviewed to clarify the deficiencies and to determine consistency of citations (i.e., that the same deficiencies in different facilities were all cited under the same standards and factors).

The nine facilities surveyed by the state agency were surveyed on the full 2786 form. These forms were reviewed and each deficiency categorized as either covered by the short form, the addendum, and those not covered by either.

The entire sample was then tabulated by listing each deficiency according to standards (Attachment #3), the nature of the deficiency, the name of the facility, and whether it was determined to be a new or existing deficiency. Deficiencies that had previously been waivered were excluded from all further consideration. Certain repeat deficiencies found in one facility were excluded from further consideration (rationale is discussed in Attachment #3).

STATISTICAL METHODOLOGY

The statistical methodology used in this study is called "acceptance sampling." The general technique is to select a random sample of size (n) from a total "field" of (N) items and reject the field as unacceptable if more than a certain number (say c) of items in the sample are defective. If the number of defective items in the sample is less than or equal to (c), then the field is considered acceptable. Rejection of the field signals a need for some additional action but does not necessarily indicate what that action should be; i.e., acceptance sampling can statistically document that a problem exists, but other methods may be needed to find the solution.

In "estimation sampling" (the type of sampling with which non-statisticians are most familiar), reliability is measured by how "good" the estimate is. For this purpose, statisticians use concepts like standard deviations and confidence intervals. These concepts do not apply to acceptance sampling since its purpose is to make an accept/reject decision rather than an estimate. The "goodness" of an acceptance sampling plan is measured by the chances of making an incorrect accept/reject decision. There are two ways to be wrong:

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A. reject a field which is in fact good
B. accept a field which is in fact bad

The statistical terminology is more complex, but we will call these type A and type B errors, respectively. In this study, a type A error would raise a false alarm, i.e., it would indicate that a problem existed in life safety code compliance where in fact there was no problem.

FINDINGS AND RECOMMENDATIONS

There were two primary objectives in the planning of this validation project. The first was to determine how well facilities found in full compliance maintained compliance over a span of almost two years between surveys, and the second was to determine how well the HCFA-2786C short life safety survey form worked as a survey instrument. Several other findings and recommendations grew out of the study.

Objective I

How well do facilities previously found in full compliance maintain their compliance when left unsurveyed for an average span of 21.2 months?

Findings and Discussion

The study reflects that full compliance is not maintained. The breakdown of compliance status at the time of the validation survey was as shown below:

	Number	Percentage of Sample
Facilities found in full compliance	3	10.0%
Facilities not meeting short form, but with no deficiencies beyond the short form	4	13.3%
Facilities not meeting short form, and having deficiencies beyond the short form (includes major deficiencies as discussed in Attachment #4)	23	76.7%

Most facilities similar to those discussed in Attachment #4 (facilities with major deficiencies) corrected their deficiencies earlier in the program. However, Valley Manor demonstrates that although full compliance has been achieved, it is possible, in a short span of time through neglect or "creative maintenance," to become seriously deficient. Extreme concern is placed on major, life-threatening deficiencies. There should not be any facilities seriously deficient at any time. In this study, all facilities were previously in full compliance, and hypothetically, should only have been found to have only minor maintenance deficiencies. Therefore, even allowing for some errors to occur over time, an acceptable field, under the acceptance sampling method, should have less than 1% of facilities with

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major, life-threatening deficiencies. If we are extremely liberal and allow for extraordinary circumstances, an acceptable field could have up to 2% deficiencies. With this in mind, we used an acceptance sampling plan with the following specifications:

N = 269 = number of facilities in state
n = 30 = sample size
c = 2 = acceptance (percentage), allowing for extraordinary circumstances
c = 1 = acceptance (percentage), not allowing for extraordinary circumstances

This sampling plan yields less than a 2% chance of a type A error for either acceptance number (i.e., either with or without allowing for extraordinary circumstances), thus minimizing the chance of raising a false alarm.

On this basis, the field could have been rejected because of Valley Manor alone, as we would not expect to find a single facility with major deficiencies. Valley Manor was only one facility out of thirty, however. Much more demonstrative of the issue is that 90% of all the facilities were no longer in full compliance. The slow build-up of deficiencies over a period of time weakened the systems for patient protection from smoke and fire. Statistically, the field would have to be rejected on the basis of sheer numbers of deficiencies found.

It is of particular interest to compare the last five columns on Attachment #3. These columns represent the percentage of facilities in our study which were found to be newly deficient in each item with the percentage of facilities in Pennsylvania and nationwide that were deficient in those items in the comparison years of 1980 and 1981. In the comparison years, all surveys were being done on an annual basis. Nine of the survey items were newly deficient in a much greater percentage of facilities than in the comparison years. They are as follows:

	% Validation	%PA-81	%US-81	%PA-80	%US-80
K14 Corridor doors	33.3	21	11	26	12
K17 Deficient smoke barriers	36.7	15	11	17	10
K19 Stairway enclosures	16.7	12	6	13	4
K23 Vertical shafts	16.7	4	3	6	3
K25 Linen and trash chutes	23.3	4	3	5	3
K37 Closure by alarm of doors in smoke and fire partitions	20.0	3	8	10	10
K45 Interior finish	10.0	4	3	7	2
K59 Maintenance of extinguishers	13.3	4	6	6	7
K63 Hazardous areas	60.0	39	21	37	21

In only two items could the percentages of facilities in the validation study be said to be much less than the percentage of facilities deficient in comparison years. They are as follows:

	% Validation	%PA-81	%US-81	%PA-80	%US-80
K26 Exits, number and type	0	3	5	6	5
K71 Smoking regulations posted	0	7	4	5	4

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The other thirteen items shown on Attachment #3 would have to be said to be more or less equal to the comparison years. K56A, smoke detector maintenance, is a new item and has no base for comparison. K60, heating, ventillating and air conditioning systems, while appearing on Attachment #3, was not one of the "anticipated" deficiencies, and only one existing deficiency was found.

It would certainly appear that the passage of time has a compounding effect on the number of facilities deficient. When the time span between surveys approached two years rather than one year, more facilities ceased to be in compliance in at least those nine items. All but one of those nine were anticipated by either the short form or the Region III addendum. The deficiencies in interior finish were not anticipated. In each case of an interior finish deficiency, the facility had added wood panelling.

The most common causes for the new deficiencies were lack of maintenance, changes in facility usage creating new deficiencies, and damage caused by telephone company employees running lines through walls.

Recommendation

It has been clearly demonstrated by the findings that full compliance is a transient condition. It cannot be said how long between surveys is too long. Certainly more than two years between surveys would be unacceptable, and continuation of annual surveys would seem to be strongly indicated.

Objective II

Did the HCFA-2786C Fire Safety Survey Report short form serve as an adequate survey instrument?

Findings and Discussion

The study indicates that only 23.3% of the facilities could have been adequately surveyed using the short form.

The original intent of the short form was to provide a survey tool that could be used by a generalist surveyor (the individual performing the health survey) to screen certain basic life safety code requirements for continued compliance. The generalist was to make a recommendation for a full life safety code survey if he/she felt it was needed. At some interval which was never settled on, but which was proposed to be as long as once every four years, a life safety code specialist would survey the facility with the full survey form. If the short form were being used, in a most perfect of all situations, by a generalist who was able to spot other conditions beyond the basic items on the short form, a full survey should have been recommended in 76.7% of the facilities included in this study. The duplication of survey time casts doubt on any perceptible economic value. In a more realistic setting, the generalist would have been briefly trained in fire safety, and trained only in those items included in the short form (a slide and tape training program developed by HCFA). The generalist would be performing the survey as a secondary mission to his purpose for being in the facility, i.e., the health survey.

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Under these conditions, it is not unreasonable to speculate that the generalist would not be likely to detect deficiencies which were not on the short form, and therefore would not recommend a full survey. It is even doubtful that a generalist would detect all of the deficiencies which could be cited under the short form. In this situation, some portion of that 76.7% of the sample would have gone uncited for life safety code deficiencies. Statistically, under the acceptance sampling method, the field would have to be rejected on the basis of sheer numbers of deficiencies found which were not on the short form.

A second suggestion was proposed whereby the fire safety specialist would continue to do the surveys, but would perform the survey using the HCFA-2786C form unless contraindicated by conditions found. There is no supportable rationale to this suggestion. Again, in 76.7% of the surveys in this study, the full form would have been required. The amount of time required for a surveyor to look at all the requirements on the long form as opposed to only those on the short form does not add an appreciable amount of time to the survey process. The multiplicty of forms does not seem advantageous.

Recommendation

The HCFA-2786C short form provides no perceptable advantage, and should not be used as a survey instrument.

ADDITIONAL FINDINGS AND RECOMMENDATIONS BEYOND THE PRIMARY OBJECTIVES IN THE STUDY

I. Testing for Operation of Smoke Detectors

Smoke detectors are now an important part of the warning system of almost every nursing home. In each facility equipped with smoke detectors in this study, the surveyors set off detectors using cigarette smoke. In four facilities, the surveyors found malfunctioning detectors. In three of these cases, the detectors did not work. In one case, it functioned locally, but did not set off the alarm (wires were not connected above the ceiling). Only two of the thirty facilities had an ongoing recorded program of detector tests. At least part of the problem is the lack of a convenient means for testing detectors. In one facility, the maintenance director had constructed an excellent testing device out of a piece of pipe on a pole with a spray can of freon in it. By pressing the pipe over the detector and triggering the freon, he could easily test his detectors. Most facilities expressed a desire to have a means of testing.

This deficiency is cited on Attachment #3 as K56A. This deficiency had no counterpart under the old form.

Recommendation

Surveyors should be advised to actually test smoke detectors unless the facility has a convincing testing program of its own. We recognize that this is not a popular suggestion because of the inconvenience in notifying fire departments, disturbing staff and patients, and resetting alarms, but the benefits outweigh the

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disadvantages. The setting off of the alarm system by smoke detectors has the additional values of enabling surveyors to observe smoke barrier doors functioning under alarm conditions. Surveyors should also share with the facilities any new methods for easy testing of detectors, and advise the facilities how to establish a maintenance program.

II. The Need for Communications Training for Surveyors

A great deal of emphasis is placed on training health surveyors in interpersonal relationships, interview techniques and oral communications. Fire safety surveyors are drilled in technology. The failure to communicate plays a role in both the number of new deficiencies and the number of overlooked existing deficiencies.

On each survey, the validation team was accompanied by the maintenance director of the facility. Many times while discussing deficiencies the maintenance director responded with "No one ever explained that to me before" or "No one ever asked me that before." For example, in several facilities surveyors found that the soiled linen storage had been moved to a different room. The new location lacked either latches, closers, or both. The surveyors explained how spontaneous combustion can occur in soiled linen, why self-closers are needed to insure people do not leave the door standing open, and why positive latching is necessary to keep the door from opening to release smoke. They had always thought that there was something special about the one particular room they had previously used for soiled linen. The previous surveyors had recited a regulation saying that the room needed a closer and latch, so they installed it, but they really didn't know why. There was a general opinion voiced that surveyors never told them why things were regulated the way they were, only that the one thing being cited did not meet the Code.

Although there were a few maintenance directors who were extremely well informed professionals who were formerly in the military or the fire service, and a few who would be hard put to comprehend the simplest concept, the average maintenance director was a sincere, handy-man type individual, who was capable and interested in learning from the surveyors.

Written communications are also a problem with surveyors. It became apparent in reviewing old survey report forms that more specific documentation is necessary. For example, when all that appears on the Fire Safety Survey Report form and the Statement of Deficiencies is "smoke barrier doors not in accordance with NFPA 80A," it does not paint a very clear picture of what was found. When the surveyor records "smoke barrier doors north corridor have gap exceeding 1/8" at meeting edge," you have a much better grasp of where and what is involved. A surveyor doing a follow-up visit can tell much easier what was wrong and if it has been corrected, and a file review after the passage of time can reveal what was happening in the facility without having to trust the memories of surveyors.

Recommendation

We strongly suggest that life safety surveyors be given some additional training in verbal communications. Regulation may correct a deficiency, but enlightenment may prevent its reoccurance, and a question posed to a maintenance man may tell the surveyor something he wouldn't find in hours of surveying.

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III. Existing Deficiencies Overlooked on Past Surveys

A disturbing factor in these surveys was that about 25% of all the deficiencies found were probably there in the past and were not cited. A few of these were glaring deficiencies, and a large number were clustered in a few facilities. A number of them were understandable, in that random chance led to their eventual discovery. For example, in one large four story facility, the surveyors happened to lift a ceiling tile that revealed a hazardous area without a wall above the drop ceiling. Investigation confirmed that there is no other place in the building that had this problem. Random chance led to the lifting of this particular tile. Incidentally, this was an example of the maintenance director saying "I knew that, but nobody asked me." Some overlooked existing deficiencies were the result of incomplete follow through. For example, a smoke barrier in an attic looked fine from the access hatch, but actually going into the attic and through an access door in the barrier showed it to be finished on only one side. Still other existing deficiencies indicated surveyor inattention for years.

Recommendation

These situations point out the advantages of rotating surveyors so that fresh eyes can view a facility. When the same surveyor visits a facility year after year, he is unlikely to go back and question what he accepted five years ago, even if he knows better now than to accept a certain situation. That is not to say a surveyor would deliberately cover up his past oversites, but it is psychologically normal to accept what you yourself did in the past as correct, and not go out of your way to look for your own mistakes.

IV. The Possibility of Finding More Efficient Survey Methods - Recommendation

The extended survey cycle and the short survey form were not created for the simple purpose of change, they were created to effect economics in the survey process. Economics which are not detrimental to safety are highly desirable.

The joint federal/state survey teams were able to survey facilities, in their entirety, for all items on the long form, in anywhere from 1-1/2 to 3 hours. Even the worst facilities took no more than four hours. The surveyors did not divide the job, they worked together as a unit. The average facility took a little over two hours complete with exit interview. In states such as Pennsylvania, where extensive travel time is involved, a surveyor may spend more time than necessary given his next scheduled facility is 150 miles away.

If a method could be worked out where fire safety surveys were not as directly tied to the health survey in time frame, clustering of facilities could be accomplished. For example, dismiss the idea that the one facility in Orangeville, Pennsylvania, 100 miles from the field office, is two months apart on the survey cycle from the second facility in Orangeville, and do them both in one day. A man day and $44.00 mileage fee would be saved. Clustering in major metropolitan areas may not save time or money, but in rural areas it could have major impact.

Needless to say, clustering of surveys cannot simply be instituted overnight, but it would be a desirable field of exploration for a state to work out a trial project with the region for experimental purposes.

HMENT #1

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		PREVIOUS SURVEY DATE	STUDY SURVEY DATE	MONTHS ELAPSED	SURVEY UNIT
ITIES IN FULL COMPLIANCE					
90	Church of the Brethren Home	09/16/80	09/02/82	24	DSI
279	Andrew Kaul Memorial Hosp.-SNF	12/10/80	09/30/82	21	DSI
305	Chandler Hall	12/24/80	12/07/82	24	RO/DSI
LITIES WITH DEFICIENCIES ON 2786C ONLY					
380	Edgehill Nursing Home	12/19/80	08/23/82	20	DSI
224	Hamilton Arms of PA, Inc.	12/08/80	09/09/82	21	DSI
415	Grandview Health Care, Inc.	11/06/80	11/04/82	24	DSI
490	Southampton Estates	05/15/81	12/07/82	19	RO/DSI
LITIES WITH DEFICIENCIES ON 2786C AND FULL 2786					
038	Charmund Nursing Home	02/03/81	12/15/82	22	RO/DSI
075	Friendly Nursing Home	04/08/81	10/04/82	18	DSI
A113	Landis Nursing Home	12/17/80	12/13/82	24	RO/DSI
A137	Marian Manor	04/21/81	12/14/82	20	RO/DSI
A188	Ross Manor Convalescent Home	03/04/81	12/08/82	21	RO/DSI
A207	St. Barnabas, Inc.	08/01/81	12/13/82	16	RO/DSI
A229	Village Vista	12/23/80	12/13/82	24	RO/DSI
A277	Homewood Retirement Center	01/08/81	01/17/83	24	RO/DSI
A350	Eastern Mennonite Home	12/15/80	12/07/82	24	RO/DSI
-5037	Barley Convalescent Home	04/ /81	12/14/82	20	RO/DSI
-5059	Collins Nursing Home	04/23/81	12/14/82	20	RO/DSI
-5114	Stenton Hall	05/12/81	12/06/82	19	RO/DSI
-5167	Valley Manor	03/12/81	12/08/82	21	RO/DSI
-5261	Buffalo Valley Lutheran Home	01/29/81	12/15/82	23	RO/DSI
-5334	Rest Haven Chestnut Hill, Inc.	05/27/81	12/08/82	19	RO/DSI
-5351	Leader Nursing & Rehab. Center-W. Reading	06/17/80	12/09/82	18	RO/DSI
-5373	O'Hesson Manor	02/11/81	02/09/83	24	DSI
-5394	Devon Manor	06/19/80	09/01/82	15	DSI
-5433	Carpenter Care Center	12/24/80	12/16/82	24	RO/DSI
-5455	Centre Crest-Centre County Home	03/26/81	01/18/83	22	RO/DSI
9-5471	Armstrong County Home	10/30/80	11/24/82	25	DSI
9-5507	Elm Terrace Gardens	05/20/81	12/07/82	19	RO/DSI
9-5525	Green Acres for Convalescents, Inc.	02/13/81	12/06/82	22	RO/DSI

verage time between surveys - 21.2 months

Health Care Financing Administration

Form Approved
OMB No. [illegible]

FIRE SAFETY SURVEY REPORT — SHORT FORM
Medicare — Medicaid

1. (a) PROVIDER NUMBER
K1

1. (b) MEDICAID I.D. NO.
K2

SHORT FORM — PART I — Operational Features/Periodic Maintenance
PART II — Critical Fire Protection Features
NOTE: THIS FORM IS NOT TO BE USED FOR INITIAL SURVEYS!

Identifying information as shown in applicable records. Enter changes, if any, alongside each item, giving date of change.

2. NAME OF FACILITY

2. (b) MULTIPLE CONSTRUCTION (BLDGS)
K3 A. BUILDING ______
B. WING ______
C. FLOOR ______

2. (c) ADDRESS OF FACILITY (STREET, CITY, STATE, ZIP CODE)

3. SURVEY FOR
☐ MEDICARE ☐ MEDICAID

4. DATE OF SURVEY
K4

K5 SHORT FORM
☐ Check here

5. SURVEY FOR CERTIFICATION OF
K6 1. ☐ HOSPITAL 2. ☐ SKILLED NURSING FACILITY 3. ☐ INTERMEDIATE CARE FACILITY 4. ☐ ICF/MR

IF "2" OR "3" OF ITEM 5 ABOVE IS CHECKED, CHECK APPROPRIATE ITEM(S) BELOW

(1) ☐ ENTIRE FACILITY

(2) ☐ DISTINCT PART OF (SPECIFY)______

(3) IF DISTINCT PART OF HOSPITAL, IS HOSPITAL ACCREDITED BY JCAH?
a. ☐ YES b. ☐ NO

6. BED COMPOSITION:

a. TOTAL NO. OF BEDS IN THE FACILITY	b. NUMBER OF HOSPITAL BEDS CERTIFIED FOR MEDICARE	c. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICARE	d. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICAID	e. NUMBER OF ICF BEDS CERTIFIED FOR MEDICAID

I HAVE CONDUCTED A FIRE SAFETY SCREENING USING THE SHORT FORM:

A. ☐ The facility meets all of the items on the form.
B. ☐ The facility does not meet all of the items on the form.
C. ☐ A complete fire safety survey is recommended.

K9: FOR STATE AGENCY USE ONLY

A. ☐ The facility MEETS based upon:
  1. ☐ Compliance with all provisions
  2. ☐ Acceptance of a Plan of Correction
  3. ☐ Recommended waivers
B. ☐ The facility DOES NOT MEET THE STANDARD.

SURVEYOR (SIGNATURE) 8. SURVEYOR I.D. NO. K10	TITLE	OFFICE	DATE
REVIEW AUTHORITY OFFICIAL (SIGNATURE)	TITLE	OFFICE	DATE

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I.D. PREFIX	YES	NO	N/A	I—OPERATIONAL FEATURES/PERIODIC MAINTENANCE	EXPLANATORY REMARKS
K51				**Sprinkler System Maintenance** — Automatic sprinkler systems are operational and have been checked and maintained.	
K52				A. ____________ Date sprinkler system last checked and necessary maintenance provided.	
				B. Show who provided the service:	
K56				Manually operated fire alarm system is provided.	
K57				The fire alarm system is tested at least monthly. (Includes any smoke detectors).	
K58				Portable fire extinguishers are provided.	
K59				Fire extinguishers are maintained.	
K61				Fuel-burning space heaters and portable electric space heaters are not used in patient areas.	
K65				**Fire Protection Plan** — The facility has in effect and available to all supervisory personnel written copies of a plan for the protection of all persons in the event of fire and their evacuation to areas of refuge and from the building.	
K66				**Evacuation Plan Posted** — The evacuation plan is posted in prominent locations on all floors.	
K67				**Fire Drills** — Fire drills are conducted quarterly on each shift at irregular intervals to familiarize employees on all shifts with their responsibilities.	
K68				**Furnishings and Decorations** — Furnishings and decorations do not obstruct exits or the ability to locate exits	
K69				All combustible draperies and curtains *(including cubicle curtains)* are maintained flame-retardant.	
K71				**Smoking** — Regulations to control smoking have been adopted and implemented and are prominently posted throughout the	

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PREFIX	YES	NO	N/A	II — CRITICAL FIRE PROTECTION FEATURES	EXPLANATORY REMARKS
K14				**Corridor Doors** — Doors to patient rooms are of substantial construction and remain in their frames when closed. (Requires a latch, roller latch or closer).	
K19				**Stairway Enclosures** — Each stairway between stories is enclosed with partitions and a fire door to prevent the spread of fire between stories. (Any doors which are held open are held open only with approved devices.)	
K39				**Stairv [illegible]** — Doors bear an appropriate sign indicating that this is a fire exit and must be kept closed.	
K40				**Lighting for Means of Egress** — Corridors, stairways and other means of egress are adequately illuminated.	
K41				Exit signs and directional exit signs are provided to mark paths of egress and are continuously illuminated with a reliable light source, and include the word EXIT in easily visible letters.	
K63				**Hazardous Areas** — Every hazardous area has automatic sprinklers or is separated by construction having at least a 1-hour fire resistance rating. Where a hazard is severe, both automatic fire protection and fire-resistive construction are used.	

K64 A. The following hazardous areas are protected by automatic extinguishing systems and/or fire separated

AES — Automatic extinguishment system
S — Separated
N/A — Not Applicable

	(1) AES	(2) S	(3) N/A	
(a)				boiler, heater rooms
(b)				incinerators
(c)				laundries
(d)				repair shops
(e)				laboratories using hazardous quantities of flammable solvents
(f)				areas storing hazardous quantities of combustibles
(g)				trash collection rooms
(h)				employee locker rooms
(i)				soiled linen rooms
(j)				kitchen (cooking equipment)
(k)				handicraft shops
(l)				gift shops storing hazardous ...ustibles

K84

FOR STATE AGENCY USE ONLY

Items Recommended for Waiver

Data Tag No. Explanation

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For Regional Office Use:	
Date of this survey	
Date of last survey	
Building type const	
Waivers	

1. Has there been any construction or renovation to the facility since the last survey, including but not limited to anything which required penetrating walls, floors, or ceilings?

2. K13 Inspect any areas detected in #1 for any unsealed penetrations.

3. K23 Vertical Openings
   K25 Inspect for any deficiencies as a result of neglect or renovation in protection of pipe and vent shafts, laundry and incinerator chutes, etc.

4. K37 Smoke Control (smoke partition doors)
   K38 Check for operation under alarm condition, check for fit of doors.

5. K26 Emergency Movement Routes
   K34 Check for any deficiencies resulting from neglect or renovation which inhibit use of, or otherwise makes routes deficient, including horizontal exits.

6. K52 Check functioning of smoke detectors.
   Note type of system.

7. K62 (Information only) Nature of sprinkler system - full or partial.

8. Other items to be noted:

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63-112 0918

ATTACHMENT #3

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LEGEND TO TABLE

K#

The identification number for each deficiency as given in the HCFA-2786 Fire Safety Survey Report (11-74).

Deficiency

Basic description of the deficiency category.

Facilities Deficient - (A)

The number of facilities having only deficiencies covered on the short form found to have deficiencies referenced to that number.

Facilities Deficient - (B)

The number of facilities having deficiencies over and above those covered on the short form which were found to have deficiencies in the referenced K number.

Total Deficient - (C)

Total of A and B.

Existing Deficient - (D)

The number of facilities listed in A or B which only had deficiencies under that K# which were believed to have existed at the time of the last survey.

Adjusted Total - (E)

The number of facilities found to have what are believed to be new deficiencies under the referenced K# (may also have had existing deficiencies).

Stenton Hall - (F)

Deficiencies were found in Stenton Hall in the referenced K#, but they were all repeat deficiencies. These were not counted as new or existing.

Total Items Under the K-Tag - (G)

The number of actual deficiencies cited under that referenced K#. If a facility had, for example, six soiled linen rooms without latches, it would be counted as only one deficiency in the column for K63 under this heading. If, for example, it had a soiled linen room door without a latch, no sprinkler in the records room and a missing closer on the kitchen door, it would contribute 3 items to this column.

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Total of G "New"

The number and percentage of the total deficiencies described in (G) which were believed to be new deficiencies.

Total of G "Existing"

The number and percentage of the total deficiencies described in (G) which were believed to have existed at the time of the last survey.

% of Facilities Deficient in C

The percentage of the 30 facilities found to have any deficiencies under the referenced K#.

% of Facilities Deficient in D

The percentage of the 30 facilities found to have only existing deficiencies under the referenced K#.

% of Facilities Deficient in E

The percentage of the 30 facilities found to have new deficiencies under the referenced K#.

Remaining Columns

National and Pennsylvania percentages of facilities found deficient for the referenced K# in the four quarters previous to the date given as provided by the Medicare/Medicaid Automated Certification System (MMACS) Table 8.

ATTACHMENT #3

TAG	DEFICIENCY	Facilities Deficient		Tot. Def.	Existing Def.	Adj. Tot.	Stanton Hall	Total Items Under K Tag	Total of G "new"		Total of G "existing"		% of Field Deficient in	% of Field Deficient	% of Field Deficient	% Deficient in PA	% Deficient in U.S.	% Deficient in PA	% Deficient in U.S.
		A	B	C	D	E	F	G	#	%	#	%	C	in D	in E	09/26/01	09/26/01	09/27/00	09/27/00
14	Corridor Doors	1	9	10		10		14	14	100	0		33.3	0	33.3	21	11	20	12
19	Stairway Enclosures		5	5		5	1	7	7	100	0		16.7	0	16.7	12	6	13	4
39	Stairway Doors		2	2		2		2	2	100	0		6.7	0	6.7	4	2	9	2
40	Exit Lighting		2	2	2	0		2	0	0	2	100	6.7	6.7	0	3	4	5	0
41	Exit & Directional Signs	2	5	7	4	3		7	3	42.9	4	57.1	23.3	13.3	10	17	9	10	9
51	Sprinkler Maintenance		2	2		2		2	2	100	0		6.7	0	6.7	9	10	12	12
56A	Smoke Detector Maintenance		4	4	1	3		4	3	75	1	25	13.3	3.3	10	-	-	-	-
56	Manual Fire Alarms		0	0		0		0	0		0				0	2	0	1	7
57	Alarm Tested Weekly		1	1		1		1	1	100	0		3.3		3.3	1	6	3	0
58	Portable Extinguishers Provided		0	0		0		0	0		0				0	2	2	0	3
60	" " Maintained		4	4		4		4	4	100	0		13.3		13.3	4	6	6	7
61	No Fuel Burning Space Heat		0	0		0		0	0		0				0	2	1	1	1
63	Hazardous Area Sep. of Sprink	1	19	20	2	18	1	62	45	72.6	17	27.4	66.7	6.7	60.0	39	21	37	21
64	Fire Protection Plan		0	0		0		0	0		0				0	0	2	1	2
66	Evacuation Plan Posted		0	0		0		0	0		0				0	3	2	5	3
67	Fire Drills		1	1		1		1	1	100	0		3.3		3.3	1	0	1	0
68	Exits Not Blocked By Furnishings		1	1		1		1	1	100	0		3.3		3.3	2	3	4	3
69	Drapes & Curtains Flame Proofed		0	0		0		0	0		0				0	2	2	6	3
71	Smoking Regs Posted		0	0		0		0	0		0				0	3	5	6	5
	SHORT FORM ENDS																		
	CRITICAL ITEMS ON ADDENDUM																		
13	Corridor Walls		6	6		6	*	8	7	87.5	1	12.5	20		20	20	7	14	6
16	Required Smoke Barriers		1	1	1	0		1	0	0	1	100	3.3	3.3	0	4	2	3	1
17	Deficient Smoke Barriers		13	13	2	11	1	21	14	66.7	7	33.3	43.3	6.7	36.7	16	11	17	10
23	Vertical Shafts		6	6	1	5		3	2	66.7	1	33.3	20	3.3	16.7	9	3	8	3
25	Linen & Trash Chutes		8	8	1	7		14	8	57.1	6	42.9	26.7	3.3	23.3	4	3	5	3
26	Exits - Number & Type		2	2	2	0		2	0	0	2	100	6.7	6.7	0	7	4	5	4
27	Exit Access		1	1		1		1	0	0	1	100	3.3	3.3	0	1	3	4	4
29	Horizontal Exits		1	1	1	0		1	1	100	0		3.3	3.3	0	1	1		
35	Doors in Line of Exit Travel		2	2		2		2	2	100	0		6.7	0	6.7	2	1	2	0
37	Closure by Alarm of Doors in FCB and Smoke Bars		8	8	2	6		14	10	71.4	4	28.6	26.7	6.7	20	3	8	10	10
	END ADDENDUM																		
	ADDITIONAL ITEMS FOUND																		
43	Emergency Lighting		1	1		1		1	1	100	0		3.3	0	3.3	4	6	5	6
45	Interior Finish		3	3		3		3	3	100	0		10	0	10	6	3	7	2
46	Floor Covering Flame Spread		2	2		2		2	2	100	0		6.7	0	6.7	10	2	11	3
60	HVAC		1	1	1	0		1	0	0	1	100	3.3	3.3	0	5	11	7	7
72	Medical Gas Systems		2	2		2		2	2	100	0		6.7	0	6.7	1	5	6	6

ATTACHMENT #4

FACILITIES FOUND TO HAVE MAJOR LIFE SAFETY CODE DEFICIENCIES

U.S. GOV'T - HCFA - III

In the course of our validations, three facilities were surveyed which were found to have major Life Safety Code deficiencies (i.e., life threatening by the number and severity). Each of the three illustrated a separate problem.

A. Valley View Manor

Valley View Manor was a perfect example of how, under a perfect system where facilities in full compliance are truly in full compliance, a facility can disintegrate and present a true danger to patient safety. There were a few deficiencies which had been overlooked in the past, but the vast majority of problems were brought about by sloppy maintenance and deliberate acts. The facility is a sprawling one story, protected ordinary building with a connected wing of non-combustible construction. The wood trussed attic space of the main building is fully sprinklered. To correct a deficiency in the past, new duct work was installed. With the incredible cold of the winter of 1981-1982, the sprinkler pipes froze and burst. They had previously been warmed by heat given off by pipes, etc. To correct the problem, the facility personnel tore out the existing smoke barriers and installed fans in the attic to circulate air from one area which had heat. Many things in the facility deteriorated from lack of maintenance, usage of areas changed creating new hazardous areas, and at one point, the alarm system was rewired so that when the alarm is pulled, the smoke barrier doors in one section remain held open and when the alarm is turned off, they close.

Ironically, this facility had changed ownership only days before our survey. Whether the deficiencies were the result of efforts to save money or ignorance of fire protection systems, the end result was the destruction of good systems and the expenditure of a great deal of money to bring the facility back into compliance with the fire code.

B. Stenton Hall

At the time of the initial cutbacks in funding, it was proposed that facilities with outstanding deficiencies and a cancellation clause be surveyed by telephone for the purpose of removing the cancellation clause. In theory, the facility would vouch that they had made corrections, and this would be verified at the time of the next survey. While this was not the most desirable method of doing things, it was a means of economizing to enable critical surveys to be done. In the case of Stenton Hall, extensive deficiencies were cited at the time of its annual survey (it had been a longstanding problem facility for health and life safety). A telephone "visit" was conducted for the purpose of the cancellation clause removal. The HCFA-2567B cleared the cancellation clause, and cleared the deficiencies in MMACS. When rankings of facilities were sent to the state agency for the next year's scheduling, based on MMACS analysis by the regional office, Stenton Hall was listed as a facility in full compliance. In retrospect, telephone "B's" should not have been put into MMACS.

When the federal validation took place, it was found that the facility, near economic collapse, had been sold just prior to the survey. The new owners, Beverly Enterprises, had taken possession three days prior to the survey. Not

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only had no corrective action been taken by the former owners to correct deficiencies cited on the previous survey, but deterioration of maintenance had created new ones as well. There was no indication of bad surveying in the past, rather this was a prime example of a facility which inadvertently benefited from federal cutbacks in funding for life safety code surveys.

C. Centre Crest - Centre County Home

This facility consists of three interconnected buildings (a center core and two additions). As a result of the validation survey, one building was found in full compliance, one had a few new deficiencies, and one was found to have extensive problems which had gone uncited since its 1971 construction. All corridor walls, all hazardous area separations, and all smoke barriers were incomplete above the drop ceiling. This was compounded by a two story lounge at one end of the three story building.

This facility is in an isolated part of Pennsylvania. The logistics of surveying this area has resulted in repetitious surveying by one person. This case points out the desirability of surveyor rotation so that the misunderstanding of one surveyor is not perpetuated in a facility.

[COMMITTEE STAFF NOTE: HCFA prepared this in early 1983.]

JUSTIFICATIONS OF APPROPRIATION ESTIMATES FOR COMMITTEE ON APPROPRIATIONS

FISCAL YEAR - 1984

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

State Survey and Certification Activities

States are required to survey and certify long-term care facilities to ensure that these facilities are structurally safe, provide for a sanitary environment, are well staffed, and have needed services available to assure Medicaid beneficiaries an acceptable quality of care. In FY 1984, there will be approximately 2,580 Skilled Nursing Facilities; 11,300 Intermediate Care Facilities; and 1,215 Institutions for the Mentally Retarded which will be certified for participation in the Medicaid program. Hospitals, laboratories, and other providers of services to Medicaid beneficiaries are deemed eligible for Medicaid participation through participation in the Medicare program.

OBRA deletes the requirement for annual inspections and allows the States to perform less frequent than annual surveys of long-term care facilities with a history of compliance with program conditions of participation. Consistent with the OBRA and Administration's efforts to reduce the Government's regulatory burden HCFA has proposed revisions to the Code of Federal Regulations, Title 42, Subpart S "Certification Procedure for Providers and Suppliers of Services." However, a moratorium has been imposed on the issuance of these regulations by TEFRA and the first Continuing Resolution of FY 1983, P.L. 97-276. If implemented, these revisions would enable State agencies to utilize variable survey cycles, ranging from 6 months to 2 years, to inspect institutions. Facilities would be scheduled for surveys based on the use of screening criteria developed from data resulting from complaints, the prior compliance history of each institution and the severity of past deficiencies. States could survey on a semi-annual basis those facilities with historically poor compliance records.

Quarterly grants to States provide Federal support for 75 percent of surveyor costs for salaries, travel, and training; and 50 percent Federal matching for all other survey related expenditures. For FY 1984, the amount required to support Medicaid survey activities is $35,135,000. This funding provides resources to States to inspect SNFs, ICFs, and ICF/MRs at acceptable survey levels. These levels, established by the Secretary in April 1982, are SNFs - 80 percent, ICFs - 75 percent and ICF/MRs - 100 percent.

EXPENDITURE DATA

The following table represents the aggregate of the States' estimates for Federal expenditures by type of service.

Federal Expenditures by Type of Service
(Dollars in Millions)

	FY 1982 Federal Share	FY 1983 Federal Share	FY 1984 Federal Share
Inpatient Hospital	$ 4,324.5	$ 4,964.7	$ 5,475.3
Mental Hospital	636.5	687.4	743.6
SNF	2,482.0	2,634.3	2,843.1
ICF/MR	1,934.2	2,170.4	2,387.1
ICF/Other	2,876.0	3,269.1	3,661.7
Physician	1,184.0	1,315.8	1,439.6
Outpatient Hospital	775.2	838.8	915.2
Prescribed Drugs	899.1	977.3	1,075.9
Other	1,788.8	2,188.3	2,455.9
Subtotal, Services	$ 16,900.3	$ 19,046.1	$ 20,997.4
Cash Flow	-88.2	+21.7	-107.7
Subtotal, MVP State Estimates	$ 16,812.1	$ 19,067.8	$ 20,889.7
Program Adjustments	-424.8	-579.9	-1,005.3
Financial Adjustments	-202.0	-235.8	+25.0
Proposed Law	---	-7.0	-293.3
Subtotal, Adjusted MVP	$ 16,589.3	$ 18,245.1	$ 19,616.1
Administration and Training	921.5	1,012.3	1,094.5
State Certification	33.1	42.0	36.3
Subtotal, SLA State Estimates	$ 954.6	$ 1,054.3	$ 1,130.8
Program Adjustments	-24.1	+30.4	+52.0
Financial Adjustments	-5.6	-3.7	---
Subtotal, Adjusted SLA	$ 924.9	$ 1081.0	$ 1,182.8
Total, Medicaid Program	$ 17,514.2	$ 19,326.1	$ 20,798.9

4. State Certification

Authorizing Legislation - Social Security Act, Title XVIII, Section 1864; Reorganization Act of 1954.

	1983 Current Estimate	1984 Estimate		Increase or Decrease
		Authorization	Request	
Total Obligations	$ 32,835,000		$ 37,532,000	$+4,697,000
Less Trust Fund Transfer	$-32,300,000		$-36,932,000	$+4,632,000
Total Budget Authority	$ 535,000	Indefinite	$ 600,000	$ +65,000

Purpose and Method of Operations:

The purpose of this activity is to ensure that institutions and agencies providing health care services to Medicare patients meet acceptable standards of health quality and safety. The State-conducted Medicaid survey and certification program is also administered by the Health Care Financing Administration (HCFA), and a description of that activity is included in the Grants to States for Medicaid account.

Annual agreements are negotiated with State licensure agencies (generally within State Health Departments) to perform health facility inspections in accordance with explicit Departmental regulations and HCFA instructions. State agencies survey institutions which request Medicare program participation and, based on their findings, make certification recommendations to the HCFA Regional Offices where final determinations are made regarding facility participation. For those facilities having deficiencies which could endanger the health and life safety of beneficiaries, a plan of correction is developed cooperatively by State/Federal staff. A majority of facilities correct these deficiencies, thus, permitting continued program participation. Facilities which do not make necessary corrections within a reasonable period of time are eliminated from the program.

Medicare survey activities are one-hundred percent Federally funded. States submit budgets each year for the estimated cost of activities which are subject to negotiation and subsequent Federal approval. States also submit quarterly cost and workload reports which are subject to Department of Health and Human Services (DHHS) audit.

The State Certification program, which was implemented in 1966, initially covered only hospital inspections; however, with the growth of the health care industry during the past decade (both services and facilities). Medicare and Medicaid coverage has expanded to include numerous types of providers and suppliers. The increase in facilities has expanded program activity from inspection of a few thousand hospitals in 1966 to oversight of 38,000 diversified health care facilities today. Levels of funding have increased annually based on the expanded number of surveys to be performed. In FY 1980, the program required $28 million for full survey coverage. During fiscal years 1981 and 1982, less than annual surveys decreased budgetary requirements to $25 million and $14 million respectively.

Major program accomplishments include: virtual elimination of multiple death disasters within certified health care facilities which result from fire, improper drug administration, dietary services etc., and the termination of facilities which have deficiencies which would result in the provision of unsafe and life threatening services to beneficiaries.

Rationale for the Budget Request:

The FY 1984 budget request of $36,932,000 for Medicare survey activity assumes a 20 percent reduction in direct SNF survey activity as well as a reduction in certain support costs and reduced non-SNF workload. These reductions, however, reflect offsets due to cost-of-living increases for State surveyor salaries, and inflation adjustments for items such as travel and communications. Based on experience, normal expansion will add 610 providers to the program in FY 1984, and will increase by an additional $1,323,000 the inspection funding required. In addition, the budget request includes $3,450,000 to survey 1,500 hospices, a newly identified provider group authorized in the Tax Equity and Fiscal Responsibility Act of 1982.

The FY 1984 funding request will support: (1) required surveyor staffing levels to administer the proposed plan; (2) continued refinement of screening criteria to identify facilities with a history of poor performance and to upgrade the quality of their services or, if necessary, eliminate them from the program; and (3) maintenance of the essential basic and specialized surveyor training courses. This funding level provides for bi-annual inspections of the estimated 35 percent of facilities having Class A deficiencies (severe) which, if not corrected, could endanger the health and life safety of beneficiaries. Necessary onsite followup surveys will be made to facilities to ensure cited deficiencies are corrected. Also, any necessary complaint investigation visits will be performed. Remaining funds will be used for surveying facilties with less severe deficiencies (Class B), and those with a history of good compliance (Class C). Both Class B and C facilities have been placed on two-year survey cycles. The requested level of funding provides approximately 64 percent coverage of facilities requesting Medicare eligibility; the Medicaid account proposes funds to support 78 percent coverage of facilities requesting Medicaid coverage. Long Term Care facilities have had a tradition of deficiency problems due to their size and complex nature; therefore, more frequent coverage is required to ensure compliance with program standards.

The Tax Equity and Fiscal Responsibility Act of 1982 provides that hospices be classified as a separate provider category in the Medicare program. During FY 1983, HCFA will develop required regulations, policies, survey forms and training programs to ensure State surveyors will properly inspect the estimated 1,500 hospice groups which will request Medicare eligibility in FY 1984.

In addition to the funds required for direct survey support, $600,000 is budgeted to fund an Interagency Agreement with the National Institute of Mental Health, which provides oversight, logistical support, and mental health experts and specialists to assist States in the performance of approximately 230 psychiatric hospital surveys.

Major objectives of the program include the revision of survey report forms together with modifications to the actual onsite survey process. These changes will provide more specific documentation of surveyors' observations in areas where conditions of participation have not been met. Such documentation will provide stronger support to enforce corrective actions and, in more serious instances, initiate termination procedures. These actions will better assure that an adequate level of patient care will be maintained in a safe and sanitary environment.

Consistent with the Omnibus Reconciliation Act and Administration's efforts to reduce the Government's regulatory burden, HCFA has proposed revisions to the Code of Federal Regulations, Title 42, Subpart S "Certification Procedure for Providers and Suppliers of Services." If implemented, these revisions would enable State agencies to utilize variable survey cycles, ranging from 6 months to 2 years, to inspect institutions. Facilities would be scheduled for surveys based on the use of screening criteria developed from data resulting from complaints, the prior compliance history of each institution and the severity of past deficiencies. States could survey on a semi-annual basis those facilities with historically poor compliance records.

HCFA will also determine the feasibility of deeming the findings of other professional organizations to be acceptable under Medicare survey and certification guidelines. In addition to hospital and Skilled Nursing Facility inspections by the Joint Commission on the Accreditation of Hospitals (JCAH), there are several organizations which also conduct accreditation programs on a National scale. These include the National League of Nursing (Home Health Agencies), and the Accreditation Council for Services to the Mentally Retarded and Other Developmentally Disabled Persons (Intermediate Care Facilities for the Mentally Retarded). Analyses will be conducted on the standards and procedures these organizations utilize, and, if appropriate, HCFA will propose that (deemed status) be granted to their accredited facilities. Prior to making any such proposal, HCFA intends to consult with the Congress, the General Accounting Office, States' Survey Agencies and groups representing facility types relative to the proposed deeming. This objective is consistent with the Administration's regulatory reform initiative and fosters improved use of Federal, State, and private sector resources, both fiscal and staffing, as well as reducing burdens on providers of health care services.

The requested funding level provides a targeted survey strategy and adequate survey levels to provide reasonable assurance that the health and safety of beneficiaries are protected.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Refer to: Division of Health Standards & Quality
Telephone No: (415) 556-0094
HS-331

Region IX
100 Van Ness Avenue
San Francisco CA 94102

May 9, 1983

Division of Health Standards and Quality - Region IX

State Agency Letter No.: 83- 12

Subject: Marginal Providers

In an effort to upgrade the conditions existing in skilled nursing facilities (SNFs) in Region IX and consequently the quality of life for the residents, HSQ is initiating an intensive review of those providers that fail their annual survey but bring themselves sufficiently into compliance at the time of the follow-up visit to permit recertification. As you know, we receive four to eight nonrenewal recommendations per month from State agencies. Of these, only one or two are processed as nonrenewals. The others manage, by one method or another, to correct enough of their deficiencies by follow-up time that the survey agency is able to recommend recertification. A few of these providers frequently fail to meet the Conditions of Participation during the annual survey.

Therefore, the following procedures will be initiated by HSQ for all SNFs that fail their annual survey but are in compliance at the time of the follow-up visit:

1. A special letter (not the routine recertification letter) will be sent to the provider. The provider will be advised of HSQ's concern over it's failure to meet the Conditions of Participation at the time of it's inspection and warned that failure to meet the Conditions at it's next survey will be grounds for nonrenewal of the provider agreement. The provider agreement in these cases will be for six months only.

2. If the provider fails it's next inspection, HSQ will review the State nonrenewal recommendation on a priority basis and make a decision on the type of nonrenewal to process.

    a. If it is determined by HSQ that the facility is a consistent poor performer, a nonrenewal letter will be sent to the provider without the benefit of a follow-up visit addressing as the basis for the nonrenewal the provider's inability to achieve and maintain compliance with appropriate Medicare requirements that will assure that the health and safety needs of patients are met. The State agency will be notified not to proceed with the usual follow-up visit.

b. If HSQ decides that the facility is not a candidate for this procedure, then HSQ will send a nonrenewal letter using only the unmet Conditions as the basis for the nonrenewal. If the follow-up visit finds the facility to be in compliance, HSQ will reopen and revise the nonrenewal decision.

For a few selected facilities, that have already demonstrated inability to maintain compliance over several past survey cycles, HSQ will proceed to step 2a immediately and institute nonrenewal proceedings based upon the already manifest poor performance.

This HSQ policy will have the following impact on the State agencies.

1. State agencies will have to provide documentation of jeopardy to patient health and safety which is sufficient to justify the nonrenewal recommendation. It will not be enough to cite a deficiency by merely restating the regulation in a mechanical fashion; examples of effects upon the patients must also be cited.

2. State agencies should not make a follow-up visit to any facility that has failed to meet the Conditions of Participation at two consecutive surveys. HSQ will request a follow-up visit if one is appropriate.

Focusing additional attention on these problem providers is consistent with HSQ policy. This process should put the targeted facility on notice that its status in the program is tenuous and the results of its next survey will be crucial to its remaining in the program. This new procedure is effective immediately.

For further information please contact your HSQ representative.

Lawrence L. McDonough

Lawrence L. McDonough

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Refer to Division of Health Standards and Quality
(415) 556-0094
HS-331

Region IX
100 Van Ness Avenue
San Francisco CA 941

May 10, 1983

DIVISION OF HEALTH STANDARDS AND QUALITY -- REGION IX

STATE AGENCY LETTER NO. 83-14

SUBJECT: Readmission to the Medicare Program following Termination or Nonrenewal
The Reasonable Assurance Requirement*

A Recent Appeals Council action has emphasized the authority and validity of the "reasonable assurance" requirement referred to above. Title XVIII of the Social Security Act precludes the automatic reinstatement of a provider that has been terminated or nonrenewed for cause simply by receiving a passing grade on a new inspection.

The "reasonable assurance" requirement for readmission has two major elements: Compliance in all areas related to the termination or nonrenewal action, and "reasonable assurance" that the deficiencies that resulted in the termination or nonrenewal will not recur. Generally, a provider will be required to operate for a period of 60 days after compliance is achieved in all areas related to the termination or nonrenewal decision before a new provider agreement will be "accepted for filing." This means that the effective date of the new agreement and the first day for which Medicare reimbursement will be available is the day that the provider provides satisfactory evidence that it has been operating in compliance with program requirements for the preceeding 60 days.

Exceptions to the 60-day period of compliance will be made where:

1. Structural changes have eliminated the reasons for termination or nonrenewal. "Reasonable assurance" will be considered established as of the date such structural changes were completed. The effective date of the agreement will be that date.

2. The provider has a history of making temporary corrections and then relapsing into the old deficiencies that were the basis for termination or nonrenewal. The effective date in such cases would be the earliest date after 60 days at which the provider establishes by satisfactory evidence that it could maintain compliance.

Request for Readmission — Upon receipt of a request from an involuntarily terminated or nonrenewed provider indicating that it desires readmission into the program, immediately contact the provider and inform it that the requirements for readmission include correction of all deficiencies that were a basis for the termination or nonrenewal and reasonable assurance that they will not recur. If, after such contact, the facility indicates that it can meet the requirements for participation, telephone the Regional Office. HSQ-RO will contact the previous servicing intermediary who will advise the HSQ-RO whether there are any outstanding financial problems, such as overpayments, that need to be resolved before the facility is readmitted. In addition, HSQ-RO will take immediate action to obtain Title VI clearance. For Medicaid only facilities, contact the Medicaid State agency.

Timing of the Survey -- Schedule a new survey as promptly as possible once the provider alleges that all deficiencies which led to the termination or nonrenewal of the provider agreement have been corrected. If the survey establishes that the aforementioned deficiencies have been corrected, a followup visit should be scheduled for 60 days after the survey to establish that the provider has now demonstrated "reasonable assurance" that these deficiencies will not recur. If the second visit does not find evidence of a recurrence of those aforementioned deficiencies, then the provider may reenter the Title XVIII program with an effective date of the second visit. Where the reapplication survey finds that one or more Conditions of Participation are not met (the same or different ones that caused the termination or nonrenewal) the new certification kit should be immediately forwarded to HSQ-RO with a recommendation of denial. Where the reapplication survey finds that all Conditions of Participation are now met, but that one or more standards which were not met at the time of the termination or nonrenewal action continue to be not met, schedule a followup visit to coincide with the correction date proposed by the provider. Should compliance be found during the followup visit, schedule a second followup visit to occur 60 days after the first followup visit to ascertain whether reasonable assurance has been demonstrated in maintaining compliance. If continued compliance is not demonstrated at the second followup visit immediately forward the certification to HSQ-RO with a certification recommendation of denial for failure to establish "reasonable assurance" that the deficiencies which caused the termination or nonrenewal would not recur

Certification -- After the survey, complete the survey report form and as part of the Certification and Transmittal, HCFA-1539, prepare a comprehensive statement that includes:

1. The basis for finding that the deficiencies which led to the termination or nonrenewal of the provider agreement have (or have not) been corrected.

2. If corrected, the statement should describe when and how this was done; the evidence showing that compliance has existed for a sufficient period of time; and the State agency's reasons for concluding that the deficiencies will not recur.

3. A description of any other deficiencies and an explanation of why the facility is nevertheless in compliance with all Conditions of Participation, or why there are no hazards to health and safety despite failure to be in compliance with requirements.

Change of Ownership — A change of ownership has no effect on the termination or nonrenewal decision if the change of ownership occurs prior to the effective date of the termination or nonrenewal. Federal regulation at 42 C.F.R. 489.18 provides that "when there is a change of ownership...the existing provider agreement will automatically be assigned to the new owner." And that "An assigned agreement is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued including, but not limited to...any expiration date." Thus, the party or parties to the terminated or nonrenewed agreement are subject to the "reasonable assurance" requirement discussed above.

In summary, a provider cannot be readmitted to the Medicare Program until the deficiencies causing the termination or nonrenewal have been corrected and the provider has provided reasonable assurance that these deficiencies will not recur. Reasonable assurance is provided when structural deficiencies are corrected and/or when the provider demonstrates compliance with all requirements (in areas previously deficient) for 60 days. The new certification is effective with the date "reasonable assurance" is provided and other certification requirements are met. A provider seeking readmission following a termination or nonrenewal decision should be thoroughly informed of these procedures.

Lawrence L. McDonough
Associate Regional Administrator

*Reference: Section 1866(c) of the Social Security Act
HCFA Regulation 42 C.F.R. 489.13 and 42 C.F.R. 489.57
SOM: Section 3744

Commonwealth of Pennsylvania

Department of Health

HARRISBURG

(717) 787-6436

8/5/83

RECEIVED
STANDARDS ALITY
REGION III
JUL 11 AM 11:2

July 7, 1983

Mr. Robert J. Taylor
Associate Regional Administrator
Division of Health Standards and Quality
Health Care Financing Administration
P.O. Box 7760, 3535 Market Street
Philadelphia, PA 19101

Dear Mr. Taylor:

I am pleased to submit the Medicare and Medicaid budget requests for fiscal year 1984. This budget reflects the funding necessary for the Commonwealth of Pennsylvania to adequately perform mandated certification activity involving all categories of Medicare and Medicaid health provider

We have prepared the budget request in accordance with instructions received in your letters. I do feel it important to point out that our 1984 Medicare budget request of $2,012,097 indicates a significant increase over estimated and actual 1983 Medicare expenditures. This is the direct result of two situations over which we had no control. First, a hiring freeze was placed on all State Agencies on December 20, 1982. As a result of this action, approximately twenty (20) vacancies in the Bureau of Quality Assurance were not filled, thus reducing expenditures substantially. Second, the original Medicare award of $953,000 dated September 8, 1982 was increased to $1,538,000 on February 3, 1983. Four months of the Federal fiscal year had lapsed when we received notification of this increase making it extremely difficult to expend the total grant award within an eight month period. Since receiving the notification, we have received approval to begin the process of filling the vacant positions. Naturally, this will increase Medicare expenditures in Federal fiscal year 1984.

Every attempt has been made to submit a conservative but realistic budget request. If you have any questions, please contact Jennifer Riseon of my staff at (717) 787-8015.

Sincerely,

H. Arnold Muller, M.D.
Secretary of Health

Attachments

SYSTEMETRICS, INC.
4520 East-West Highway, Suite 600 • Bethesda, Maryland 20814 • (301) 986-0111

October 26, 1983

Mr. David Schulke
Room G32
Dirkson Senate Office Building
Washington, D.C. 20510

Dear Mr. Schulke:

Enclosed you will find the MMACS tape that you requested. Also enclosed is a file layout and documentation on encoded variables. If you have any questions, feel free to contact either Barry Blandford, Portia De Filippes or myself.

Sincerely,

Luann Reeves

LAR/lr

Enclosure

a division of Data Resources, Inc.

MMACS SNF/ICF RESEARCH FILE

FILE DESCRIPTION

DATA ELEMENT NUMBER	VARIABLE NAME	TYPE	BYTES	POSITION	
				FROM	THRU
01	Facility Name	Alpha	38	1	38
02	Facility Street Address	Alpha	38	39	76
03	City and State	Alpha	33	77	109
04	Zip Code	Numeric	5	110	114
05	Provider Number	Alpha	6	115	120
06	Type of Facility	Numeric	2	121	122
07	Type of Control	Numeric	2	123	124
08	Certified Beds, March 1981	Numeric	4	125	128
09	Registered Nurses, March 1981	Numeric	3	129	131
10	Licensed Practical Nurses, March, 1981	Numeric	3	132	134
11	Physical Therapists	Numeric	2	135	136
12	Occupational Therapists	Numeric	2	137	138
13	Speech Therapists	Numeric	2	139	140
14	Licensed Pharmacists	Numeric	2	141	142
15	Social Workers	Numeric	2	143	144
16	Dietitians	Numeric	2	145	146
17	Services	Numeric	17	147	163
18	Facility Group	Numeric	1	164	164
19	Certified Beds, May, 1981	Numeric	4	165	168
20	Non-Certified Beds	Numeric	3	169	171
21	Total Facility Beds	Numeric	4	172	175
22	Registered Nurses, May, 1981	Numeric	3	176	178
23	Licensed Practical Nurses, May, 1981	Numeric	3	179	181
24	Staffing Group	Numeric	1	182	182
25	Nursing Deficiency	Numeric	1	183	183
26	Rehab Deficiency	Numeric	1	184	184
27	Hospital Based or Not	Numeric	1	185	185
28	Space	Numeric	1	186	186
29	Total Medicare Bills - Inpatient Part A	Numeric	9	187	195
30	Medicare Bills with Reimbursement - Inpatient Part A	Numeric	9	196	204
31	Medicare Bills without Reimbursement - Inpatient Part A	Numeric	9	205	213
32	Amount of Reimbursement - Inpatient Part A	Numeric	7.2	214	222
33	Total Medicare Bills - Inpatient Part B	Numeric	9	223	231
34	Medicare Bills with Reimbursement - Inpatient Part B	Numeric	9	232	240
35	Medicare Bills without Reimbursement - Inpatient Part B	Numeric	9	241	249
36	Amount of Reimbursement - Inpatient Part B	Numeric	7.2	250	258
37	Total Medicare Bills - Outpatient Part B	Numeric	9	259	267
38	Medicare Bills with Reimbursement - Outpatient Part B	Numeric	9	268	276
39	Medicare Bills without Reimbursement - Outpatient Part B	Numeric	9	277	285
40	Amount of Reimbursement - Outpatient Part B	Numeric	7.2	286	294
41	Nurses (RN & LPN, May, 1981)	Numeric	8	295	302
42	Beds (Certified & Non-Certified, May, 1981)	Numeric	8	303	310

MMACS SNF/ICF RESEARCH FILE

FILE DESCRIPTION

DATA ELEMENT NUMBER	VARIABLE NAME	TYPE	BYTES	POSITION	
				FROM	THRU
43	Nurse to Bed Ratio, May, 1981	Numeric	8	312	318
44	Allied Health Professionals (Social Workers, Pharmacist, Dietitian)	Numeric	8	319	326
45	Therapist (Occupational, Physical, Speech)	Numeric	8	327	334
46	Staffing Group 2	Numeric	8	335	342

MMACS SNF/ICF RESEARCH FILE
DATA DEFINITION

D.E. No.	NAME	DEFINITION
01	Facility Name	Name of Medicaid/Medicare Certified SNF or ICF
02	Facility Street Address	Street Address (number and name)
03	City and State	City and State
04	Zip Code	Zip Code
05	Provider Number	Provider number assigned by H.C.F.A. First 2 digits = state code, 3rd. digit = provider type, 4th thru 6 digit = provider number State Code: 01 = AL 02 = AK 03 = AZ 04 = AR 05 = CA 55 = CA 06 = CO 07 = CT 08 = DE 09 = DC 10 = FL 11 = GA 12 = HI 13 = ID 14 = IL 15 = IN 16 = IA 17 = KS 18 = KY 19 = LA 20 = ME 21 = MD 22 = MA 23 = MI 24 = MN 25 = MS 26 = MO 27 = MT 28 = NE 29 = NV 30 = NH 31 = NJ 32 = NM 33 = NY 34 = NC 35 = ND 36 = OH 37 = OK 38 = OR 39 = PA 40 = RI 41 = SC 42 = SD 43 = TN 44 = TX 45 = UT 46 = VT 47 = VA 48 = WA 49 = WV 50 = WI 51 = CY Provider Type : 5 = Medicare/Medicaid SNF A = Medicaid Only SNF E = Medicaid ICF
06	Type of Facility	01 = Skilled Nursing Facility (SNF) 02 = Extended Care Facility of Hospital 03 = Extended Care Facility of Rehab. Center 04 = Extended Care Facility of Domiciliary Institution 05 = Distinct Part of SNF 06 = Christian Science Sanitarium 07 = General Intermediate Care Facility 08 = Institution for Metally Retarded 09 = Combination 10 = Other

MMACS SNF/ICF RESEARCH FILE
DATA DEFINITION

D.E. No.	NAME	DEFINITION
07	Type of Control	01 = Church (Voluntary Non-Profit) 02 = Other Voluntary Non-Profit 03 = Proprietary 04 = State Government 05 = County Government 06 = City Government 07 = City/County Government 08 = Hospital District 09 = Other Non-Federal Government
08	Certified Beds	Number of beds certified as of March, 1981
09	Registered Nurses	Number of F.T.E. RNs employed as of March, 1981
10	Licensed Practical Nurses	Number of F.T.E. LPN's employed as of March, 1981
11	Physical Therapists	Number of F.T.E. Physical Therapist employed as of March, 1981
12	Occupational Therapist	Number of F.T.E. Occupational Therapists employed as of March, 1981
13	Speech Therapists	Number of F.T.E. Speech Therapists employed as of March, 1981
14	Licensed Pharmacists	Number of F.T.E. Licensed Pharmicists employed as of March, 1981
15	Social Workers	Number of F.T.E. Qualified Social Workers employed as of March, 1981
16	Dietitians	Number of F.T.E. Dietitians employed as of March, 1981
17	Services	Services Provides By Staff or Under Arrangement 0 = Not Provided 1 = Provided by Staff 2 = Provided Under Arrangement Position 148 Physical Therapy 149 Outpatient Physical Therapy 150 Occupational Therapy 151 Speech Pathology 152 Outpatient Speech Pathology 153 Social Services 154 Recreational Act

MMACS SNF/ICF RESEARCH FILE

DATA DEFINITION

D.E. No.	NAME	DEFINITION
17	Services (Continued)	155 Pharmacy 156 Clinical Laboratory 157 Diagnostic X-ray 158 Administration & Storage of Blood 159 Denistry 160 Podiatry 161 Ophthalmology 162 Psychological Services 163 Other
18	Facility Group	Type of Facility 1 = Medicare/Medicaid SNF Only 2 = Medicaid SNF Only 3 = Medicare/Medicaid SNF/ICF (Distinct Part) Facility 4 = Medicaid SNF/ICF (Distinct Part) Facility 5 = Medicare/Medicaid (Swing/Dual) Facility 6 = Medicaid SNF/ICF (Swing/Dual) Facility 7 = Medicaid ICF Only
19	Certified Beds, May, 1981	Number of beds certified as of May, 1981
20	Non-Certified Beds	Number of non-participating beds as of May, 1981
21	Total Facility Beds	Data Element 19 plus data Element 20
22	Registered Nurses, May, 1981	Number of F.T.E. RNs employed as of May,. 1981
23	Licensed Practical Nurses, May, 1981	Number of F.T.E. LPNs employed as of May, 1981
24	Staffing Group	Quality Matrix Developed By HCFA

	Low Nurse	Meets Nurse	High Nurse
No Rehab.	1	2	3
1 Rehab. Service	4	5	6
2 Rehab. + 1 Other Professional Discipline	7	8	9

MMACS SNF/ICF RESEARCH FILE

DATA DEFINITION

D.E. No.	NAME	DEFINITION
25	Nursing Deficiency	Number of Nurse Deficiencies reported on the most recent survey prior to March, 1981
26	Rehab. Deficiency	Number of Rehab. Deficiencies reported on the most recent survey prior to March, 1981
27	Hospital Based or Not	0 = Not Hospital Based 1 = Hospital Based
28	Space	Blank
29	Total Medicare Bills-Inpatient Part A	Total number of Medicare bills submitted for Inpatient Part A services
30	Medicare Bills with Reimbursement-Inpatient Part A	Number of Medicare bills for Inpatient Part A services that were paid
31	Medicare Bills Without Reimbursement-Inpatient Part A	Number of Medicare bills for Inpatient Part A services that were not paid
32	Amount of Reimbursement-Inpatient Part A	Amount paid by Medicare for Inpatient Part A services
33	Total Medicare Bills-Inpatient Part B	Total number of Medicare bills submitted for Inpatient Part B services
34	Medicare Bills with Reimbursement-Inpatient Part B	Number of Medicare bills for Inpatient Part B services that were paid
35	Medicare Bills without Reimbursement-Inpatient Part B	Number of Medicare bills for Inpatient Part B services that were not paid
36	Amount of Reimbursement-Inpatient Part B	Amount paid by Medicare for Inpatient Part B services
37	Total Medicare Bills Outpatient Part B	Total number of Medicare bills submitted for Outpatient Part B services
38	Medicare Bills with Reimbursement-Outpatient Part B	Number of Medicare bills for Outpatient Part B services that were paid
39	Medicare Bills without Reimbursement-Outpatient Part B	Number of Medicare bills for Outpatient Part B services that were not paid

MMACS SNF/ICF RESEARCH FILE
DATA DEFINITION

D.E. No.	NAME	DEFINITION
40	Amount of Reimbursement-Outpatient Part B	Amount paid by Medicare for Outpatient Part B services
41	Nurses	Number of F.T.E. RNs plus LPNs that were employed as of May, 1981
42	Beds	Total number of beds (certified plus non-participating) as of May, 1981
43	Nurse to Bed Ratio	Ratio of number of beds per Nurse as of May, 1981
44	Allied Health Professionals	Presence of allied health professionals (Social Worker, Licensed Pharmacist and/or Dietitian) on staff as of March, 1981 0 = None 1 = 1 Discipline 2 = 2 or more Disciplines
45	Therapists	Presence of therapists (Occupational, Physical and/or Speech) on staff as of March, 1981 0 = None 1 = 1 Discipline 2 = 2 or More Disciplines
46	Staffing Group 2	See next page

Staffing Group 2

Facility Group	RN + LPN Staff to Total Bed Ratio	No Physical, Speech or Occupational Therapist	Any 1 of Physical, Speech or Occupational Therapist	Any 2 of Physical, Speech or Occupational Therapist Plus Any 1 of Dietician, Social Worker or Pharmacist
1-6	One Nurse to 9 or fewer Beds	7	8	9
1-6	One Nurse to 10-13 Beds	4	5	6
1-6	One Nurse to 14 or more Beds	1	2	3
7	One Nurse to 13 or fewer Beds	7	8	9
7	One Nurse to 14-22 Beds	4	5	6
7	One Nurse to 23 or more Beds	1	2	3

JOHN HEINZ, PA., CHAIRMAN

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United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, D.C. 20510

December 16, 1983

The Honorable Margaret Heckler
Secretary, Department of Health and Human Services
Washington, D.C. 20201

Dear Madame Secretary:

Constituents have brought to my attention persistent substandard conditions at a nursing home located in Fayette County, in Pennsylvania. In response to their complaints, forwarded to Region III of the Health Care Financing Administration in October by my office, HCFA officials conducted an unannounced inspection. HCFA is now, as a result of the inspection, considering decertification of this medicare/medicaid certified skilled nursing facility.

As several years of HCFA records document poor conditions at this facility, the strong action proposed by HCFA seems to be quite appropriate. In fact, it may be that similar action should have been initiated some time ago by State officials. States' licensing and certification officials, however, are frequently reluctant to invoke the strong measure of decertification, allowing substandard conditions to recur year after year in some long term care institutions.

I understand that you are now considering final action on a regulation, the Alternate to Decertification of a Long Term Care Facility, which will give to States needed flexibility to more promptly produce improvements in problem facilities such as the one recently brought to my attention.

I support your efforts to authorize States to impose a moratorium on admissions prior to final decertification action against a long term care facility. I urge you to sign this regulation, which will improve our ability to ensure quality long term care is available to our aged and disabled citizens.

Sincerely,

John Heinz

JOHN HEINZ
Chairman

JH:ds

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Health Standards and Quality Bureau
1849 Gwynn Oak Avenue
Baltimore, Maryland 21207

DEC 23 1983

Mr. Robert D. DiCenso, President
Association of Health Facility Licensure
and Certification Directors
Division of Facilities Regulation
Rhode Island Department of Health
75 Davis Street
Providence, Rhode Island

Dear Mr. DiCenso:

This letter is in response to your request of December 7, 1983 to provide the Association of Health Facility Licensure and Certification Directors with information regarding FY 1983 and 1984 State Certification budget allocations for regions and States. This data is provided on the attached table.

Allocations to regions are based on a formula of historical costs and workload. My staff are currently working with representatives from regions to test the formula and determine if more equitable allocations may be possible. Regional Offices are responsible for negotiating and approving State's budgets. In reviewing the data provided, you may observe that some regions maintain a reserve which is available to States as additional requirements become necessary during the course of the year.

With the recent passage of FY 1984 Appropriations, P.L. 98-139, an additional $2,068,000 was made available for survey activities. Of this amount, $1,302,000 has been awarded to the National Academy of Sciences to support the Congressionally mandated study of the LTC survey process. The remaining $766,000 will be allocated to regions for States which can utilize additional survey resources.

Please contact me when I can be of further assistance.

Sincerely yours,

Philip Nathanson, Director
Health Standards and Quality Bureau

Attachment

STATE CERTIFICATION BUDGET ALLOCATIONS

		FY 1983		FY '984	
		Regional Allocation	State Allocation	Regional Allocation	State Allocation
ALL REGIONS		$32,299,044	$31,649,079	$36,932,000	$35,372,551
REGION I	TOTAL	2,111,960	2,101,850	2,062,700	2,062,700
	CONNECTICUT		791,340		785,689
	MAINE		117,490		104,000
	MASSACHUSETTS		778,846		808,194
	NEW HAMPSHIRE		63,724		85,000
	RHODE ISLAND		248,375		178,217
	VERMONT		102,075		101,600
REGION II	TOTAL	4,242,250	4,239,645	4,299,200	4,092,487
	NEW JERSEY		709,290		967,669
	NEW YORK		3,379,200		2,948,659
	PUERTO RICO		141,595		166,599
	VIRGIN ISLANDS		9,560		9,560
REGION III	TOTAL	2,779,370	2,740,370	3,620,900	3,519,631
	DELAWARE		76,673		97,093
	DIST. OF COLUMBIA		128,581		136,219
	MARYLAND		359,361		569,186
	PENNSYLVANIA		1,591,083		2,036,946
	VIRGINIA		250,544		302,342
	WEST VIRGINIA		334,123		377,845
REGION IV	TOTAL	4,921,400	4,586,745	5,705,100	5,705,100
	ALABAMA		694,200		882,507
	FLORIDA		1,256,300		1,473,903
	GEORGIA		561,409		697,052
	KENTUCKY		446,881		500,198
	MISSISSIPPI		400,271		484,277
	NORTH CAROLINA		458,657		682,651
	SOUTH CAROLINA		259,827		367,628
	TENNESSEE		509,200		616,884
REGION V	TOTAL	5,643,349	5,489,214	6,826,800	6,084,320
	ILLINOIS		1,212,649		1,464,230
	INDIANA		568,888		650,642
	MICHIGAN		1,319,907		1,433,340
	MINNESOTA		513,778		723,511
	OHIO		1,187,077		1,027,810
	WISCONSIN		686,915		784,787
REGION VI	TOTAL	2,853,730	2,853,730	2,790,800	2,790,800
	ARKANSAS		347,564		339,858
	LOUISIANA		367,539		352,259
	NEW MEXICO		205,403		205,339
	OKLAHOMA		341,423		360,110
	TEXAS		1,591,801		1,533,234
REGION VII	TOTAL	1,443,203	1,396,472	1,997,400	1,643,230
	IOWA		364,980		511,307
	KANSAS		283,793		273,817
	MISSOURI		482,137		628,580
	NEBRASKA		265,562		229,526
REGION VIII	TOTAL	1,464,661	1,432,088	1,684,200	1,681,239
	COLORADO		360,276		415,732
	MONTANA		302,301		347,967
	NORTH DAKOTA		240,344		238,440
	SOUTH DAKOTA		199,290		232,522
	UTAH		219,350		278,368
	WYOMING		110,027		168,160
REGION IX	TOTAL	5,280,521	5,280,521	6,423,200	6,271,334
	AMERICAN SAMOA		---		---
	ARIZONA		354,456		420,908
	CALIFORNIA		4,520,023		5,499,666
	GUAM		---		---
	HAWAII		180,685		152,170
	NEVADA		225,357		198,590
REGION X	TOTAL	1,558,600	1,528,444	1,521,700	1,521,710
	ALASKA		138,868		183,731
	IDAHO		132,506		190,777
	OREGON		335,634		486,763
	WASHINGTON		921,436		660,439
	FOREIGN				

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

12 198

[JAN 12 1984]

The Honorable John Heinz
United States Senate
Washington, D.C. 20510

Dear ~~Senator~~ John Heinz:

Thank you for your recent letter supporting publication of the proposed regulation, "Alternatives to Decertification of Long Term Care Facilities." This regulation would broaden the Department's enforcement powers to ensure that long-term care facilities comply with Federal health and safety standards. A draft Notice of Proposed Rulemaking is in the final stages of Department review, and I am expecting to receive it for my review and decision shortly.

I appreciate your expression of strong support for the proposed regulation. Please be assured that your perspectives will be seriously considered in the decision-making process for this rule.

Sincerely,

Margaret

Margaret M. Heckler
Secretary

[COMMITTEE STAFF NOTE: HCFA prepared this analysis of the Medicaid Inspection of Care in the Spring, 1984.]

Inspection of Care Review

Executive Summary

DRAFT

I. Introduction

The attached report presents the results of an extended study by the Health Standards and Quality Bureau (HSQB) of inspection of care (IoC) review programs throughout the country. We initiated the study in order to assess the overall effectiveness of current IoC programs, focusing on those States which have integrated IoC reviews with survey and certification reviews. HSQB staff conducted site visits to ten States with integrated survey and IoC review programs and collected detailed information on IoC programs in all other States via a questionnaire completed by HSQ regional office staff. We consider survey and IoC reviews to be integrated when one team conducts both reviews during the same facility visit and links the findings. The major findings of the study are summarized below.

II. Findings

Page No.

- IoC Regulations/Statute
  - inexplicit, subject to broad interpretation by States
  - regulations contain only suggested areas for review
- Quality of IoC Review — pp. 3-5
  - lack of consistency among State programs
  - no assurances regarding what areas are reviewed and thoroughness of reviews
  - over reliance on reviewer judgement due to absence of written guidelines in most States
- Funding for IoC Review — p. 5
  - wide variations among States, with accompanying quality variations
- Benefits of Integration — pp. 6-9
- Federal monitoring of IoC review — pp. 10-11
  - IoC performance measured in terms of procedures rather than effectiveness
  - lack of meaningful Federal sanction activity
  - inefficient system marked by lack of coordination among regional divisions

III. Recommendations

- Regulatory revisions — p. 12
  - establish minimum required review areas for IoC
  - include current suggested areas as well as others based on task force recommendations

- **Development of Interpretive Guidelines** pp. 12-15
  - institute a more efficient, focused approach to IoC review
  - reduce differences in State interpretations while retaining flexibility
  - guidelines should address following areas: preparation, onsite responsibilities, minimum quality review, record review, report of findings, follow-up visits, enforcement actions, State guidelines, information sharing
- Required **integration of survey and IoC reviews*** p. 16
  - eliminate duplicative review efforts by States
  - produce time and cost savings for State agencies
  - strengthen IoC and survey findings
  - eliminate conflicting findings, promote consistency
  - has support of both consumer and provider groups
- Upgraded Federal Monitoring pp. 16-17
  - encourage validation surveys to evaluate substantive aspects of State IoC reviews and implementation and effectiveness of revised review procedures
  - explore possibility of FFP reductions based on substance of IoC findings
  - reorganize regional monitoring responsibilities to unify/standardize IoC monitoring
- Federal Training for IoC Review p. 17
  - reinstitute training for IoC reviewers on a national basis, similar to surveyor training
  - ongoing training should discuss intent of regulations and guidelines and suggested approaches to review

IV. Attachments

1. Summary of Findings of State Review Forms and Guidelines
2. Summary of Data From Questionnaire
3. Comparison of IoC and Survey Processes
4. Draft Guidelines
5. Guidelines to Survey Agencies on Using IoC Reports

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* Integration -- One team conducts both survey and IoC reviews during the same visit and links the findings.

INSPECTION OF CARE REVIEW

BACKGROUND

The requirements for Inspection of Care (IoC) review are mandated by Sections 1902 (a)(26)(B), (C) and (31)(B), (C) and 1903 (g)(1)(D) of the Social Security Act. IoC is one of several Title XIX Utilization Control requirements specified under CFR 42 Part 456.600 of the Federal Code of Regulations. The IoC process consists of a review by a State review team of **each Medicaid** recipient in a long term care (LTC) facility to determine the appropriateness of placement and the quality of the recipient's care and services. All State plans for medical assistance must provide for IoC review in institutions for mental diseases (IMDs), skilled nursing facilities (SNFs), intermediate care facilities (ICFs), and intermediate care facilities for the mentally retarded (ICFs/MR). (The required review process is specifically known as medical review in SNFs and IMDs and independent professional review in ICFs and ICFs/MR.)

According to the statute and regulations, States must perform the following IoC review responsibilities:

1. Annual inspections must be conducted by review teams composed of physicians or RNs and other appropriate personnel.

2. The reviewers must have personal contact with each recipient and review each recipient's record.

3. The team must review the care provided to recipients, including: a) the adequacy of the services available to meet health, rehabilitative, and social needs and promote the maximum physical, mental and psychosocial functioning of recipients and b) whether recipients in psychiatric facilities or institutions for the mentally retarded receive active treatment. We refer to both of these reviews as quality of care review. The regulations present items reviewers may consider when making quality review decisions -- e.g., plan of care, provision of ordered services, progress toward meeting objectives of plan of care.

4. The team must determine the necessity and desirability of continued placement in the institution or feasibility of meeting the recipient's health care needs through alternative institutional or noninstitutional services (level of care review).

5. The team must prepare reports of findings containing recommendations on the adequacy, appropriateness, and quality of services provided. Reports must include specific findings about individuals. Copies must be sent to the Survey agency.

6. The Medicaid agency must take corrective action based on the recommendations.

The statute also requires a State to prepare quarterly reports providing evidence that it has an effective program of control over the utilization of institutional services, including an effective program of medical review of the care of recipients in IMDs, SNFs and ICFs.

An idea which has generated a great deal of interest over the last few years is that of integrating the IoC review process with survey and certification reviews. As stated earlier, we define integration as one team conducting a facility survey and IoC review on the same visit and linking findings together. In June, 1980, HCFA conducted a symposium among major groups and organizations concerned with certification surveys and the review of patient services in long term care facilities to discuss common areas of interest. The major topic of discussion was the integration of survey and IoC review. The group concluded that it was premature to mandate integration before collecting more information and taking into consideration the concerns of States and the public. During the past fiscal year the Health Standards and Quality Bureau (HSQB) has studied the IoC review program primarily to determine whether the integration of IoC review with survey and certification reviews would be advantageous in terms of efficiency and quality. However, our study and our recommendations encompass all aspects of the IoC review program.

PROJECT METHODOLOGY

During the past year HSQB staff contacted other components within HCFA to begin gathering data on the operation of IoC review programs. We discovered that no component within HCFA approves IoC review protocols or provides input into the development of State IoC review programs, nor does any component monitor State performance in appropriately conducting level of care and quality of care reviews. Federal oversight of IoC review is limited to assuring that States meet procedural requirements such as conducting annual visits and meeting team composition requirements. Regional Offices conduct limited onsite reviews to determine whether facilities are meeting a number of UC requirements (such as the timeliness of physician certifications and recertifications and plans of care); however, these reviews do not address IoC requirements.

Because of the lack of available information, we developed a detailed questionnaire to collect basic information on the IoC review program in all States. Major areas covered included budget, administration, the review process (including review criteria and guidelines), documentation of findings, and review results. Central Office staff conducted site visits to 10 States with integrated survey and IoC review programs to observe the review process, meet with State officials and complete the questionnaires. Regional Office staff completed questionnaires for the remaining States.

This report is based on our observations, interviews with State agency staff, review of the questionnaires and other HCFA reports, and discussions with HCFA staff. The information collected provided a general picture of most States' IoC review programs. However, the questionnaires do not always provide a totally complete and accurate description. Not all Regions provided complete information, and only a few site visits were conducted by Regional staff. Also, State officials were understandably reluctant to point out possible weak areas in their programs. Notwithstanding these limitations, we feel the study substantially upgrades the available information on the IoC programs that HCFA partially funds.

PROJECT FINDINGS

Our study indicates that some IoC review programs place adequate attention on both utilization and quality of care. States that have developed such programs have placed considerable efforts into developing review protocols, assuring that staff conduct review as planned and taking action to see that facilities respond to findings. Unfortunately, all States do not carry out IoC review programs with the same degree of effectiveness and efficiency; some States only meet the minimum regulatory requirements or less. Weak regulations, the absence of updated Federal guidelines and lack of substantial monitoring have impeded the successful operation of the program from a national perspective.

The Statute and regulations concerning IoC review are generally inexplicit and place minimal requirements on States. They are subject to broad interpretation and have resulted in wide variation among State IoC programs. Although each State carries out the same general responsibilities outlined earlier, methods of carrying out IoC review vary in terms of emphasis, administration and items reviewed.

1. Diversity in the administration of State IoC programs

The majority of States (34) conduct IoC reviews independent of survey and certification reviews. We refer to these as nonintegrated programs. In thirteen of these States the responsibility for IoC reviews and surveys is located in the same State Department. Fifteen States conduct integrated reviews and one State employs a combined program of review (two teams visit a facility at the same time). Six States use Professional Standards Review Organizations to conduct part or all of the State's IoC review responsibilities.

State IoC teams range in size from one to eleven with a national average of 3.3 persons per team. Team size is generally determined by the number of IoC reviews to be performed in a given facility. All States use an R.N. on a team, and most include a social worker. In most instances, physicians serve as consultants. However, some physicians join the team for a portion of the IoC visit.

Based on a limited number of site visits, we estimate that the number of reviews conducted by one team member during one day can range from 8 to 25 recipients. Some States stipulate the number of reviews each reviewer must perform in a day. For example, Arkansas allows for twenty-five recipients and their records to be reviewed in one day. In some States both an R.N. and a social worker must review every recipient while in others the R.N. reviews every recipient while the social worker only reviews a sample of recipients. Some States conduct reviews inefficiently, relying almost entirely on field staff to decide how best to accomplish the task within the time allotted for review.

2. Variations in State review programs

As discussed earlier, IoC review is composed of two major functions: quality of care review and level of care review. Quality of care review is concerned with the appropriateness of care provided to each recipient. Level of care review determines the necessity and desirability of continued placement in the institution or feasibility of meeting the recipient's health care needs through alternative institutional or noninstitutional services. The degree to which individual States carry out these reviews varies greatly.

A review of the quality review forms and guidelines submitted with the questionnaires indicates that except for collecting information on activities of daily living, no one quality review area is included on all State forms. (Forty-four States submitted forms and guidelines at our request.) For instance, only 73% of the respondents' forms cover nursing services, 48% include an area for personal contact/observation, and only 23% address the recipient's psychological needs. Only 43% of respondents indicated that they utilize quality record review guidelines and only 32% use observation guidelines. In most instances, quality record review and observation guidelines are limited. States generally rely on the reviewer's professional judgement and take few measures to assure consistency among staff. (See Attachment 1 for further information.)

Since the regulations are subject to broad interpretation, a State's particular circumstances may dictate how it reads those regulations. For instance, States vary widely in their interpretation of the requirement for personal contact and the time devoted to this activity usually relates to the budget, number of staff on the visit and amount of time allotted for the visit. In some States, the team may quickly observe the recipient in a matter of seconds; in others, staff must complete an observation and interview form which assures all recipients receive the same type of review regardless of time constraints. In one State, a sample of recipients receives a very intense interview/observation while the other recipients receive a less intense review.

The record reviews required in the regulations are also open to the interpretation of States. The regulations merely require a review of each recipient's medical record and include items reviewers might consider when making determinations about the adequacy of services. Record reviews are conducted for two purposes: quality of care and level of care. The reviewer can compare documentation on the recipient's condition, services ordered, and services delivered with their observations, and make appropriate decisions on the quality of such services. The staff person must also review the medical record to ascertain the recipient's level of functioning and care needs to determine whether he is receiving the required services at the most appropriate setting. Observation alone does not provide the needed information.

A few States conduct an extensive quality record review which includes more patient care areas than suggested in regulations, some States have tailored their quality review to those items suggested in regulations, and others appear to conduct record reviews strictly for the purposes of making level of care decisions. Many States' review forms cover level of care review items exclusively with few or no quality items included. The quality review area is left to the reviewer's discretion in many cases, leading to variations in the scope of review among reviewers and States.

The way States report findings and problems also varies. Of the States responding to our questionnaire, only 81% (29 of 36 States submitting data) indicated that their report of findings includes individual recipient quality of care problems, although Section 456.611 of the regulations requires such reports to include specific findings about individual recipients. Only 71% of States (32 of 45 States submitting data) indicated that they require facilities to develop plans of correction in response to findings. Although the majority of States claimed to follow-up on IoC findings, we learned during site visits that once some States have conducted the visit or received a plan of correction, the forms/reports are filed away and no further action is taken. See Attachments 1 and 2 for additional data.

3. Budget

A State's budget level is a primary factor affecting the quality of its review program. Budgets control team size, time spent on facility visits, and ability to revisit facilities if significant problems are noted. Low budgets may prevent States from reviewing records and observing recipients carefully and may not permit the time needed for interviewing recipients.

Limited budget data was submitted to HSQB by 20 States (See Attachment 2). Of the data submitted, budgets ranged from $44,000 to $3.5 million for IoC review. FY 1983 review dollars budgeted per Title 19 recipient ranged from $12 to $124. The wide range in IoC funding is another indication of the variation in the quality of these programs and the varied methods of conducting review. With the limited data available at this time, we are unable to make more statistically valid cost comparisions, including the differences between integrated and nonintegrated States.

4. Benefits of integrating IoC review with the survey and certification process.

Certification surveys and IoC reviews both have the same purpose of insuring appropriate services are provided to patients. A certification survey determines whether a facility has the capacity for delivering patient care services, including a review of the facility's physical structure, ability to meet life safety code (LSC) requirements, and a review of administrative policies and procedures; however, this process always includes a review of patient care (usually a 10% sample of patients) to validate the more "structural" findings. IoC review concentrates on determining whether the services provided to each Title XIX recipient are adequate to meet that recipient's needs and that continued placement in the institution is appropriate. Regardless of the differences in orientation, the actions followed in performing reviews of patient care are similar. The chart in Attachment 3 summarizes the similarities and differences between the two.

While the review of patient care has always been an essential part of certification surveys, we feel that this component of the review process needs greater emphasis and have developed a modified survey tool which addresses patient care and outcomes exclusively. Under this process, policies and procedures are only reviewed when patient care and outcomes indicate structural problems exist. The tool covers eight survey conditions (seven of which are covered during IoC review), and it follows the same review process utilized by many IoC programs. Emphasis is placed on patient observation, interview, and medical record review.

The survey tool and process, although now in the developmental stages, has strong support from within HCFA as well as support from States, consumer groups, and providers. Since we intend to utilize this process in the future, and it essentially follows the typical IoC review methodology, the issue of integration takes on even greater importance since duplication between the two programs will increase. The major differences that will remain are that surveyors will review only a sample of patients and will still maintain responsibility for surveying the facility's physical structure and adherence to LSC requirements, while the IoC team will review 100% of Title XIX recipients.

Considering the importance this issue, we included as one focus of our study the effectiveness of review systems in States that have integrated IoC review with the survey and certification process. Our study concluded that the integration of survey and IoC review substantially benefits both programs in numerous ways, beyond eliminating duplication. The following benefits were noted:

- Elimination of Duplication. As discussed above, both programs evaluate patient services by reviewing medical records and observing and interviewing patients, even though surveyors review a sample of patients while IoC reviewers review all Title XIX recipients. Seven patient related survey conditions (nursing, dietary, rehabilitative nursing, social services, activities, physician services, and pharmacy) are also covered during IoC review. When these review processes are carried out by one team, the information collected during IoC quality reviews can be used to evaluate facilities for survey purposes.

- Time Savings. Since surveyors can obtain substantial information from the IoC portion of the integrated review process, survey time is saved. For some States the implementation of an integrated program has resulted in cost savings through the reduction of reviewer positions. In others, the additional time has allowed staff to provide further consultation to facilities, focus greater effort on poorer facilities, and conduct additional follow-up visits.

- Cost Savings. Staff travel and per diem are often reduced since each facility receives one less visit a year, and less staff may be needed on a visit. Also, if survey and IoC review activities are integrated under one organizational component, the need for two separate management structures is eliminated.

- Improvements in Survey Findings. The two processes are complementary in that IoC findings provide a large base of information to support survey deficiencies which in turn add clout to IoC findings. IoC information collected is readily available and useful in making certification decisions. As stated above, IoC review includes all Title XIX recipients where the certification survey usually only reviews a 10% sample of patients. The greater amount of patient information collected during IoC reviews enhances the survey process by looking more closely at the patient care process and evaluates more completely the quality of a facility's care and services. Facilities have difficulty disputing IoC and survey findings when the State provides them with the names of patients with problems related to the findings.

- Strengthening of IoC Findings. Most integrated States cite systemwide IoC problems as survey deficiencies. Since the IoC findings can affect a facility's recertification, they take on greater importance and are generally taken more seriously by the facility.

- o Improved Communication and Decision Making Under This Approach. Under an integrated review program, information is shared formally and informally throughout the visit and during a pre-exit conference. Continual interaction among members increases the team's knowledge of the facility and improves its ability to evaluate the care and services provided by a facility.

- o Elimination of Conflicting Findings Between Survey and IoC Teams. Conducting survey and IoC reviews at one time eliminates conflicts that can result when information is collected and care evaluated at two different points in time. Since one component is responsible for both functions and the same staff conduct survey and IoC reviews, the survey and IoC findings concerning the quality of care and services are consistent.

- o Shared Personnel. The IoC review team and the survey team use the same health professionals to review patient care. IoC is usually performed by an R.N. and a social worker. These two health professionals are almost always involved in certification surveys. Integration of the two processes benefits State administration by making it possible to use the same staff for two functions.

- o Cross-training. In most integrated States, staff receive training for both survey and IoC review. The ability to perform both functions permits management greater flexibility in scheduling visits and allows much flexibility among the team while onsite.

Attachment 2 lists the percentage of States citing these and other benefits from integration. In addition, both consumer and provider groups have expressed support for the integration of IoC review with the survey process.

- + The Association of Health Facility Licensure and Certification Directors (AHFLCD) solicited the opinions of its members and presented a position paper to HCFA in January 1983. AHFLCD's position supports the consolidation of IoC review with certification surveys of long term care facilities with the combined process being carried out by the health standard setting agency of each State.

- + The Association of State and Territorial Health Officials (ASTHO), being the parent organization of the AHFLCD, has ratified this position.

- + In September 1983 the National Coalition of Citizens for Nursing Home Reform (NCCNHR) presented a Consumer Statement of Principles for the Nursing Home Regulatory System - State Licensure and Federal Certification Programs to HCFA. In it, NCCNHR stated that integration of IoC review and survey would be one possible way of maximizing the usefulness of IoC information.

- During the Subpart S workgroup meetings, both providers and consumers have expressed support for integration of IoC review and the survey process. This group was established to reach agreement on proposed changes to certification regulations.

Some States that formerly conducted their survey and IoC programs in different Departments only integrated review when required to do so by State law. Once review was integrated, the staff in these States felt the change was beneficial. In other integrated States, the Welfare Department still maintains control over IoC review but contracts with the Health Department to conduct the reviews. In most integrated States both functions are located in one Department. All integrated States believe they have benefited from the change, although some States have realized greater benefits than others and conduct superior programs to others due to the quality of the IoC component.

Even though full integration has proved to be extremely beneficial, we believe that improved coordination and information sharing between States can also improve both programs, though not to the extent found under a fully integrated approach. If IoC review findings are shared with the survey agency on a timely basis, surveyors may utilize the information when making certification decisions. However, the two components should attempt to schedule visits relatively close together to assure the IoC information is current. The IoC findings can help to validate survey findings by providing a wide base of information, and can also indicate those areas that need to be reviewed closely by the survey team. In addition, the IoC team can focus its efforts on problem areas noted by survey teams. By coordinating efforts, the IoC component can provide the survey agency with information on problem areas so that the agency can be alerted to potential deficiencies. Virginia is one State that has realized many benefits through closer coordination of the two processes.

The primary reason most States have not integrated review is that the functions are usually located in two different Departments (61% of nonintegrated States). The most common situation finds the survey program in the Health Department and IoC review in the Welfare Department. Although each program is theoretically required to share and utilize findings from the other, the information is in practice either not shared or not used. The timing of reviews can make the information outdated in many instances. In many nonintegrated States, facilities receive conflicting information due to different interpretations made by each organization. We found that these and other problems were overcome by integrating the two programs.

See Attachment 2 for other reasons why States chose not to integrate review.

5. Federal Monitoring of State IoC Review Programs

- Scope of Current Federal Monitoring. Our central concern regarding current IoC monitoring activities involves the scope of the IoC review validations. Under the present system, States are required to submit satisfactory quarterly showings that they are operating an effective utilization control (UC) program. Section 1903(g)(1) spells out the required evidence by which a State shows that it has an effective UC program. In terms of IoC, the quarterly showings are to indicate that "such State has an effective program of medical review . . . whereby the professional management of each case is reviewed and evaluated at least annually by independent professional review teams." Section 1903(g)(5) specifies the method to calculate the FFP reduction to be taken against the State when a State makes an invalid showing.

  BQC's regional component, the Division of Financial Operations, is now responsible for the collection of monitoring information on this requirement. Regional Office review, however, is overwhelmingly mechanical since only the presence or lack of documentation is of concern. No conclusions are drawn regarding areas such as appropriateness of individual recipients' placement, adequacy of care, or level of care determinations.

  Thus, the State's quarterly showings have become only an indication of procedural and not quality performance. The term "effective utilization control program" should mean that not only does the program work procedurally, but that it succeeds in properly identifying those persons in need of a different level of care, not in need of institutional care, or not receiving services required by their individual plans of care. We need evidence that the State agencies are routinely making these distinctions, making them accurately and taking appropriate corrective action as necessary. At present, the quarterly showings reflect none of these elements of an effective utilization control program. If HSQB is to properly fulfill its quality assurance responsibilities, we must assure that the monitoring of IoC review addresses the adequacy of State review performance.

- Scope of HCFA's Authority to Take FFP Actions. A critical issue which has yet to be fully resolved is whether or not HCFA has the authority to substantively challenge a State's individual utilization control findings and to take FFP action based on that challenge. This issue has a great deal of impact on our efforts to assure that States conduct effective review programs. States now have a significant fiscal interest in obtaining continued Medicaid reimbursement for recipients who would otherwise be financial dependents of the State. Particularly in cases where a State owns and operates the facilities involved, a State agency has little incentive to identify the inadequacies or absences of needed services for individuals. Since the States operate the utilization control program themselves, and since there is a far greater fiscal incentive to maintain recipients on Medicaid than to remove them from the system, some Federal oversight is needed as an effective challenge to State actions.

In a recent opinion dealing with ICFs/MR, OGC stated that " . . . HCFA has always interpreted these utilization control provisions as requiring only that a State demonstrate that proper procedures have been followed in each case. If a State's quarterly showing assures that all the requirements have been performed, the Secretary will find the showing satisfactory on its face." In view of this consistent historical precedent, OGC did not feel that UC disallowances based on a Federal challenge to a State's substantive determinations could be sustained under current Federal regulations. However, HSQB, BQC, and BERC are in agreement that OGC may have misinterpreted the question at hand and not completely addressed the issue of substantive challenges. BERC is independently preparing a response to OGC. According to our interpretation of "effective utilization control program", quarterly showings should provide evidence that such programs in fact result in control over the utilization of the program and not simply an indication that the procedures for utilization control operated during that quarter. We believe that the statute does contain language regarding the validity of State findings which can support substantive challenges and subsequent FFP disallowances.

o Organization of Federal Monitoring. The current Federal monitoring system lacks a coordinated system for effectively monitoring IoC review programs. Present program guidelines have produced a system of segmented Regional and Central Office responsibilities for the oversight of State utilization control functions, including IoC reviews. These responsibilities are currently divided among three Central Office bureaus (HSQB, BPO, BQC) and their respective Regional Office counterparts (DHSQ, DPO, DFO), without any organized communication among the components. We believe that this arrangement produces confusion, cost inefficiencies and overall inability to initiate effective federal action when it is needed.

A Region VIII task force recently completed a study dealing with utilization control monitoring practices and identifying areas in need of additional emphasis and better coordination of resources. The task force was a joint effort including representatives from all three involved divisions. Region VIII's study substantiated our belief that there is a need for greater coordination of effort in assessing a State's utilization control program.

RECOMMENDATIONS

Although the IoC review program applies to Medicaid recipients only, the Federal government contributes a significant percentage of the costs to carry out this program. HCFA should therefore assure that States carry out effective programs which meet minimum standards for review beyond procedural requirements. Current regulations only provide suggested areas of review, and many States do not necessarily include those areas as a part of their review criteria. As stated earlier, some States focus on level of care review and include minimal quality review items on their forms or merely a blank area for observations. We believe that the program should be improved in the following ways.

1. Revise IoC Regulations

We recommend that the IoC regulations be revised to clarify what minimum areas we expect all States to include in observations of recipients and in reviews of their records. Although States should continue to have flexibility to develop their own review forms and guidelines, we believe that specifying minimal areas of review is necessary to assure that all Title XIX recipients in all States receive an adequate quality of care review. More specifically, we recommend that States be required to include the review items under 456.610 of Subpart I in their process of making review determinations. A task force of health professionals should present recommendations for: 1) expanding Section 456.610 (e) to include additional observational areas, and 2) adding other review items deemed important to evaluating patient care and services. The regulations should at a minimum, require interviews of a sample of coherent recipients, and the percentage of recipients in the sample should be specified based on the task force's recommendation.

2. Issue New Guidelines That Include a Suggested Approach to IoC Review

We should provide States with revised Federal guidelines that discuss review areas and approaches in greater detail. Such guidance will help States to develop more efficient and effective quality review programs. Existing federal guidelines are now 10 years old and few States have based their programs on them. In our review of the materials and forms submitted by States, none utilized the suggested forms, and the review areas covered by most States were substantially less than suggested. We believe that more practical and efficient IoC review guidelines are necessary if we expect States to follow the guidelines. We have attached a draft copy of updated guidelines (Attachment 4) which place a priority on the efficient use of time and personnel where most needed. The major change included in the guidelines is a focused approach to review.

States are encouraged to conduct a brief review of all recipients and an intense quality review of a sample of recipients. The sample of recipients receiving the intense review are selected during an initial tour of the facility. Recipients selected are those with special physical problems or care needs and those showing signs of poor care. We also recommend that a focused approach to level of care review be taken.

We have several objectives in establishing the IoC review model provided in the guidelines. One objective is to reduce the differences in State interpretations of the IoC regulations by establishing a set of minimum review areas that all States should use. Consistent interpretation of requirements across State IoC review programs would increase the usefulness of IoC findings to State Survey Agencies. The survey agencies will know what areas are covered by the IoC review teams and will be able to use this information to avoid duplication of effort in States where the two programs are nonintegrated. We have also developed guidelines for the survey agencies suggesting ways to coordinate their activities with the State IoC review program and make more effective use of IoC information. See Attachment 5.

Another objective is to develop a system workable in all States while at the same time allowing States some degree of flexibility to tailor the system to their own needs. We settled on a simple and straightforward review method rather than more sophisticated approaches conducted by some States since these tended to be complicated and not easily adaptable to other States. Our guidelines present a minimum set of review areas for State use and encourage States to embellish them according to their own needs and concerns.

Focusing IoC review on both level of care and quality of care was a major objective in developing the IoC review model. While all States review the level of care for each recipient, not all review the quality of care and services the recipient is receiving. We feel that a balanced approach to these two areas of review is preferable and that the best approach is to focus review where it is most needed and beneficial.

Furthermore, if States were required to use a minimum set of review criteria for IoC review, we could set up and maintain a national data base on recipients in long term care facilities. The data would allow us to be more responsive to requests for such information from Congress and other Federal and outside parties. Accurate data could be provided within short timeframes. The data base would be similar to, or part of, the MMACS data now maintained on providers. We would request States to provide us with recipient data that is summarized by facility. As written, the guidelines provide for the report of findings to include aggregated data. We recommend that a task force be organized to explore this possibility.

The following is a brief description of the components that comprise the recommended IoC review model.

- o Preparation for visit. The guidelines discuss several steps to take in preparing for facility visits.

- o Onsite review responsibilities. The regulations specify that at least one physician or R.N. must be in involved in IoC reviews as well as other appropriate health and social service personnel as needed. The guidelines discuss the areas of review for which the different disciplines would be responsible, depending on whether or not consultants are used.

- o Minimum quality review components. The guidelines recommend that each State should include the following areas in its IoC review process:

  - Patient observation/interview. Regulations require that patient observation and interview be conducted on every Title XIX recipient. The proposed guidelines specify what patient observations should entail and the type of questions that should be asked in interviews. We suggest that the reviewers tour the facility and observe each recipient for indicators of problems (more detail given in the guidelines). Those recipients that appear to have problems would then receive an indepth observation and record review to assure that their needs are being met. The guidelines suggest that a 20% sample of recipients be selected for indepth review. This process focuses review on recipients with the greatest needs.

  - Record Review. The statute and regulations require that each recipient's record be reviewed annually.

    - + Quality Record Review. In our model the record of every Title XIX recipient will be reviewed utilizing a minimal number of items. The records of the recipients selected by the reviewers for indepth observation will be reviewed in greater detail than those of the remainder of the Title 19 patients in the facility.

    - + Level of Care Record Review. Our model provides an option for States to concentrate level of care review on recipients with the most potential for changing levels. We feel this focused approach is effective and makes the most efficient use of staff. States are encouraged to develop criteria for recipients with the potential to move to a higher or lower level (e.g., in a facility 2 years or less, unstable condition) and to conduct a full level of care review for those recipients. Recipients not meeting the criteria would not receive a level of care review but would still be reviewed for quality of care purposes. Of course, this method of review would be optional; States would determine whether to continue conducting full level of care assessments and reviews of all Title XIX recipients. Even if recipients with little likelihood of changing levels of care do not receive a utilization review by the IoC team, these recipients do receive periodic reviews by a facility-based UR committee according to a specific schedule, following set criteria. As a check on the committees, State survey agencies determine whether they carry out their functions according to Federal regulations.

- Reports. The guidelines suggest that IoC reports address both findings concerning individual recipients and any systemwide problems identified. All findings should be documented to assist the State in its monitoring of the correction of problems. Written IoC reports should be provided to the survey agency to assist in carrying out its responsibilities and provide support for survey deficiencies.

- Follow-up visits. The State should conduct follow-up visits to monitor the correction of problems identified during IoC review. The State may consider arranging with the survey agency for assistance in this area.

- Enforcement action. The type of enforcement action used by most States is withholding payment for those recipients determined to be at an inappropriate level of care. Other forms of enforcement are also necessary to deal with individual and systemwide quality problems as well as level of care problems. The guidelines recommend that States empower their Single State Agencies with sanction authorities to be used in addition to withholding payment (e.g., suspension of admissions, vendor hold. See Attachment 2 for others.) Several States have taken such measures and found them to be successful. By giving additional clout to IoC findings, the IoC process could become a more effective tool for monitoring the care given to the LTC population as a whole.

- State guidelines. To assure consistency among its reviewers, States should establish guidelines for determining if a systemwide problem exists within a facility. The presence of one serious problem always warrants the citation of a deficiency on the IoC report. However, often a minor problem will be found in the care of several recipients. States need to set parameters to assist its reviewers in deciding when to cite IoC problems to assure that all facilities receive a fair evaluation.

- Information sharing with State Survey Agency. The State should make every effort to provide the survey agency with IoC reports on a timely basis. It is important that the survey agency receive the reports promptly so that any IoC findings will be current and useful to the Survey agency in making certification decisions. (See guidelines in Attachment 5.)

3. Require the Integration of IoC and Survey Review Processes

Beyond the recommendation that IoC review efforts be focused to utilize resources more effectively, our study concluded that the integration of survey and IoC review substantially benefits both programs. We consider nonintegrated programs inefficient due to overlapping areas of responsibility present in both survey and IoC reviews. We feel that regulatory changes and updated guidelines will serve to assure all States receive the greatest benefits possible from an integrated process. Because of our positive findings concerning integrated programs, we strongly recommend that States be required to integrate surveys and inspection of care review functions and that a proposal for legislative change be submitted which would require integration. We feel States should have the option to decide how best to carry out integrated programs within their organizational structures.

Mandating the requirement to integrate IoC review with the survey process would require statutory change. Since 1986 is the earliest we could effect a change, we should, during the interim, direct our efforts to facilitating the coordination, and the eventual integration, of the two processes. Closer coordination and information sharing between the two components would benefit both processes and allow both to better focus their review efforts.

4. Upgrade the Federal Monitoring of State IoC Review Programs

In conjunction with a revised approach to IoC review, we recommend changes in the current Federal monitoring practices for IoC activities. We believe that the effectiveness of monitoring could be upgraded by employing DHSQ health professionals on IoC validation surveys. Using health professionals on IoC validation surveys would make it possible to better evaluate the substantive aspects of the State's IoC reviews. We believe that such surveys would help to identify States which are not operating an effective IoC program. This reinforced monitoring effort would also allow us to pinpoint which States have instituted the revised guidelines and better evaluate the effectiveness of the new procedures for IoC review.

Another monitoring issue which needs to be further addressed is the authority of HCFA's regional components to initiate either FFP disallowances or termination actions relative to individual utilization control findings. Although a recent OGC opinion found no precedent for such disallowances, OGC did not completely rule out the possibility of disallowances based on Federal challenges to a State's substantive UC findings. They indicated a willingness to further discuss the issues raised in the initial opinion, including the extent to which the statute does authorize such an approach. We intend to further explore the possibility, first through a more specific OGC opinion and perhaps later through revised regulatory language. In the interim, we strongly recommend that Federal monitoring efforts begin to address the substance of IoC findings, even if no immediate FFP reductions can be imposed as a result of the findings.

Further, as suggested by Region VIII's utilization control task force, we recommend that DHSQ become the focal point for regional utilization control matters, in order to take better advantage of the extensive monitoring experience and health expertise of DHSQ staff. Observations made at onsite reviews by the DHSQ staff would supplement procedural information already collected by DPO/DFO in order to achieve the best possible overall evaluation. DPO/DFO would continue to collect the same information as in the past but would need to make it accessible to DHSQ. The national implementation of such a system would result in standardizing the Regional Office UC/IoC effort from State to State and provide an opportunity for sharing information about the best practices utilized. If DHSQ assumes these recommended responsibilities, additional staff positions may be required.

5. Resume Federal Training for IoC Review.

The Medicare/Medicaid Management Institute had begun to conduct training for IoC reviewers shortly before it was disbanded. Since then IoC training has not been conducted on a national basis. Resuming a national training program for IoC review would promote greater consistency among State review programs. Training should consist of two types: a) a one time session for administrators of State programs to assure that their programs are tailored to national concerns; and b) an ongoing training course for IoC reviewers similar to the Basic Surveyor Training Course now conducted by HSQB. Training could discuss the intent of our regulations and guidelines and provide suggested approaches to review.

Attachment 1-1

Summary of Findings on Review Forms and Guidelines

In Part I of the IoC questionnaire we requested States to submit review forms and guidelines used in their IoC review programs as well as examples of reports provided to facilities. Forty-four (44) States responded to this request. The information below summarizes our findings related to review forms and guidelines.

- Forty-three percent of the responding States use one form to accomplish several tasks, including IoC level of care, quality review and other utilization control review responsibilities such as reviewing timeliness of physician certifications and recertifications.

- All forty-four States collect information concerning each recipient's activities of daily living (ADLs).

- Other than ADLs, no review area was included on all State forms. The percentage of States including particular review areas on their forms is listed below:

-- Medical-nursing	73%
-- Medical-physical	61%
-- Plans of care	61%
-- Social	48%
-- Personal observation	48%
-- Medications	45%
-- Progress notes	43%

- State guidelines vary tremendously in content and the degree of guidance on how to review specific areas.

- Many States limit their guidelines to level of care criteria.

- Few States use guidelines/criteria to help assure consistency among reviewers' review approaches and decision making processes (e.g., determining when patient care problems should be reported to facilities and corrective action required).

Attachment 2-1

SUMMARY OF DATA SUBMITTED FROM THE IoC QUESTIONNAIRES

STRUCTURE OF REVIEW PROGRAM

- Review Systems within States:

Type of Review System	No. of States	Percentage of States
Nonintegrated	34	68%
Integrated (Maine, Rhode Island, Vermont, New York, South Carolina, Tennessee, Wisconsin, Texas, Arkansas, Missouri, Colorado, Utah, Wyoming, Alaska and Idaho)	15	30
Combined (Virginia)	1	2

- Responsibility for the survey/IoC program:

	*No. of States Where Survey and IoC Functions are in Same Dept.	%	*No. of States Where Survey and Ioc Functions are in Different Dept.	%	No. of PSROs Conducting IoC Review	%
Nonintegrated	11	22	23	46	6	12
Integrated	7	14	8	16	-	-
Combined	1	2	-	-	-	-
Total	19	38%	31	62%	6	12%

*Including PSROs

- Previous category for the IoC review process:
  - Of the 32 responding nonintegrated States, the following review system was utilized: 27 or 84 percent of the States have always been nonintegrated; 2 or 6 percent were combined; and 3 or 9 percent were integrated.
  - Of the 15 integrated States, the following review system was utilized: 2 or 14 percent have always been integrated; 11 or 79 percent were nonintegrated; and 1 or 7 percent was combined.

NOTE: Items in each category with less than a 5% response will remain blank.

PROGRAM ADMINISTRATION

NONINTEGRATED STATES ONLY:

- Reasons for Not Integrating Survey and IoC Review System:

- Feels two separate review systems are superior to an integrated system	63%
- Feels two visits will result in better surveillance of facilities	63
- Difficult to coordinate activities of two organizations	38
- Unwilling to move both functions into one agency	13
- Each team has different functions and focus (facility capability vs. focus on patient needs/care received)	13
- Lack of cooperation between two agencies	6
- Lack of qualified personnel, due to budgetary contraints	6
- Other: (Examples of responses)	47

  + Historical practices
  + It is not feasible to cut PSRO contract
  + Administratively not feasible to integrate
  + Presently not cost effective

INTEGRATED STATES ONLY:

- Reasons for Changing to an Integrated System:

- To avoid duplication	64%
- To save on costs	64
- To save time	36
- To reduce burden on provider	36
- Reduce conflicting interpretations through uniform application of regulations and requirements	14

- Other: (Examples of responses)	50%
+ Feels that it is a better process	
+ To assure significant IoC problems are cited by the survey team	
+ Budget reduction	
+ Stop adversary relationships between the survey and the IoC staff	
+ Stop provider manipulation of the two processes	
+ Improvements in patient care, more actions, and better support for activities	

o Administrative Changes Resulting from Implementation of the Integrated Process

- Change in organizational structure	57%
- Change in office location	50
- Reduction in staff	21
- Other: (Example of response)	7
+ Change in IoC reviewers	

o When the Process was Integrated, Surveyors and IoC Staff:

- Were trained to carry out the other function	79%
- Received training on how to work together as a team	21
- Participated in the development of the system and form	21
- Received intensive training	14
- Received minimal training	7
- Other: (Examples of responses)	22
+ The use of a procedures book, periodic meetings	
+ Onsite training and the use of the IoC manual	

Attachment 2-4

BOTH NONINTEGRATED AND INTEGRATED

o Overall Distribution of IoC Expenditures and Number of Title 19 Recipients

Budget	States
Less Than $40,000	0
40,000 - 279,999	5
80,000 - 519,999	5
520,000 - 759,000	2
760,000-1,099,999	1
1,100,000 or More	7
*Total	20

Budget/Per Recipnt	States
Less Than $20.00	4
20 - 39.00	3
40 - 59.99	6
60 - 79.99	3
80 - 99.99	2
100 or More	2
*Total	20

Title 19 Recipients Receiving IoC Reviews	States
Less Than 2,000	3
2,000 - 31,999	33
32,000 - 61,999	9
62,000 - 91,999	0
92,000 - 121,999	2
122,000 or More	1
*Total	48

*Only those States that submitted data.

Attachment 2-5

o IoC Budget and Budget/Per Title 19 Recipient By Responding States:

NONINTEGRATED

STATE (14)	BUDGET	TITLE 19 PATIENTS	DOLLARS PER PATIENT
Alabama	$ 356,570	16,000	22.29
Georgia	1,401,747	100,000	14.02
Kentucky	629,883	15,000	41.99
Mississippi	348,287	12,370	28.16
North Carolina	1,217,081	19,285	63.11
Illinois	674,141	56,000	12.04
Indiana	1,001,464	20,000	50.07
Minnesota	1,142,000	34,000	33.59
Iowa	1,048,138	18,000	58.23
Montana	187,466	4,000	46.87
North Dakota	285,952	3,600	79.43
South Dakota	344,961	4,100	84.14
Hawaii	43,548	3,208	13.57
Nevada	144,328	2,500	57.73
INTEGRATED (6)			
South Carolina	$ 140,000	11,900	11.76
Wisconsin	3,518,521	36,721	95.82
Texas	9,600,000*	58,000	--
Colorado	806,000	17,000	47.41
Wyoming	72,000	1,100	65.46
Idaho	373,200	3,000	124.40

*This figure contains UR costs.

Attachment 2-6

- Experience of IoC Review Staff:

- No Nursing Home Experience Required	72%
- Nursing Home Experience	28

- Training:

- Onsite Observation	89%
- State Course	58
- Orientation	16
- Other: (Examples of responses)	40

  - + Periodic Meetings
  - + Use of Procedure Manual
  - + Personnel participation in the development of system and form

- Three most frequently found disciplines on an IOC team:

- Registered Nurse	100%
- Social Worker	80
- Physician (including both full and part-time)	48

Attachment 2-7

o Average Team and Facility Size:

	National	Nonintegrated	Integrated
- Average Team	3.3 persons	2.7 persons	4.6 persons
*Range		*(1 to 6)	*(2 to 9)
- Minimum Team Average	2.2 persons	2.1 persons	2.7 persons
*Range		*(1 to 6)	*(1 to 9)
- Maximum Team Average	4.7 persons	+4.8 persons	4.5 persons
*Range		*(1 to 11)	*(1 to 9)
- Average Facility	100 beds		
*Range		*(8-500 beds)	*(60-120 beds)

+Maximum team range and average are greater for nonintegrated States because the bed sizes in some of these States are greater.

REVIEW PROCESS

INTEGRATED STATES ONLY:

o Each Team Member:

- Conducts both IoC and survey review on each visit	71%
- May conduct either IoC or survey review, but performs only one function per visit	29
- Conducts only IoC or survey review at all times	14

o The IoC Reviewers and Surveyors:

- Meet together while onsite	100%
- Hold exit conferences	93
- Hold planning meetings	53

Attachment 2-8

BOTH **NONINTEGRATED AND INTEGRATED** STATES:

o Team Preparation Before IoC Visit

	TOTAL PERCENT	INTEGRATED	NONINTEGRATED
- Previous IoC Findings	91%	71%	100%
- IoC Follow-ups	65%	43%	75%
- Survey Reports	67%	86%	59%
- Complaints	67%	50%	75%
- Other:	43%		

(Examples of responses)

+ Review utilization review minutes
+ Federal survey report
+ Nurses' notes; computer printouts
+ New admissions
+ State ombudsman report
+ Team meetings

o Patient Observation By Team:

- Observe all recipients and interview all coherent recipients	67%
- Intensely observe and interview a sample of recipients and observe the remainder less intensely	28
- Quickly walk through observing all recipients/interviewing some	24
- Other: (Examples of Responses)	24

+ All recipients are observed; some receive more intense review if problems noted in their medical record
+ Observe and interview all recipients

Attachment 2-9

- Patient Selection (In those States where only a sample of recipients are observed or receive an intense observation - 24 States)

- Recipients With Questionable Problems	50%
- Random Selection	17
- Other: (Examples of Responses)	21
+ Both random selection and recipients with questionable problems	
+ Assess new admissions	
+ Select recipients using a visual assessment tool	

- Facility Review Methods Differ Because of Facility Size:

- Yes	25%
Difference In Review Methods:	
- Time spent in facility	34
- Team Change	29
- Intensity of observation/interview	0

- State Actions When Recipients not at Appropriate Level of Care:

- Change reimbursement rate	34%
- Refer recipients to a placement agency	34
- Other: (Examples of Responses)	72
+ Action taken by single State agency	
+ Discuss with facilities, if isolated problem	
+ Refer to UR committee with specific recommendations	
+ Notify physician on record and the facility; termination of payment	
+ Notice of action is sent to beneficiary; facility is notified to arrange placement	

Attachment 2-10

INTEGRATED STATES ONLY

o If facility has high percentage of recipients at an incorrect level of care or a history of problems in this area, the State:

- Works with the UR committee/administrator to resolve the problem	33%
- Halts new admissions to the facility	33
- Fines the facility	11
- Other: (Examples of Responses)	44

+ Refer to survey agency, if facility-wide

+ Withhold payment

DOCUMENTATION OF FINDINGS

NONINTEGRATED STATES ONLY:

o Facility-Wide Patient Care Problems are Detected and Reported Based on Individual Problems Identified:

- Yes	100%

o Problems Detected During IoC Review:

- Discuss at exit conference	94%
- Cite on State IOC form	85
- Do not put findings in writing	6
- Written statement is sent to the administrator	6
- Other: (Examples of Responses)	40

+ Physician is contacted, if necessary

+ May be resolved with staff at time of IoC visit

Attachment 2-11

PATIENT CARE PROBLEMS

INTEGRATED STATES ONLY:

o Problems Detected at IoC Review:

- Cite on Federal survey form - If systemwide	93%
- Discuss at exit conference	87
- Cite on State IoC form	80
- Cite on consolidated State IoC/survey form	13
- Other (Examples of Responses)	20

- + Summary of findings (not a notice of violation) that some areas currently in compliance and not yet at a deficiency level. However, it may degenerate into a deficiency status in an ensuing survey if certain steps are not taken.
- + Refer to survey agency, if facility-wide

o Individiual Care Problems are Cited as Survey Deficiencies Based on:

- Judgment of the entire team	67%
- Judgment of the surveyor responsible for completing that section of the survey form	33
- Decision criteria set by State	7

o Reports Used in the Integrated Process:

- Separate State IoC and survey report forms	79%
- Consolidated form for IoC and survey findings	14
- Survey report form only	7

Attachment 2-12

BOTH NONINTEGRATED AND INTEGRATED STATES

o Seventy-one percent of the thirty-two responding States require facilities to respond to IoC findings with a Plan of Correction:

Plan must respond to:

- Individual patient care problems	81%
- General facility-wide problems identified through individual patient review	81

o State Action Against Problem Facilities:

- Suspension of Admissions	58%
- State Initiates Relocation of Resident	54
- Receivership	28
- Injunctive Relief	23
- Facility Reclassification	23
- Criminal Relief	19
- Terminate provider agreement	12
- Civil Forfeiture	9
- Denial of payment	5
- Fine	5
- Reimbursement reduction	5
- Revocation of license	5
- Other:	65%

+ Temporary license with conditions
+ Vendor Hold
+ Probationary license
+ Reduce licensed capacity

Attachment 2-13

o STATE FOLLOW-UP ON IOC FINDINGS:

NONINTEGRATED STATES ONLY:

- IoC staff follow-ups	91%
- Survey staff follow-ups	49
- No IoC follow-up	6

INTEGRATED STATES ONLY:

- Follow-up by person or team responsible for both functions	54%
- State does not follow-up on IoC findings	23
- Other: (Examples of Responses)	
+ Survey staff	
+ Integrated staff follow-up	

RESULTS OF INTEGRATION

o Integration has resulted in the following:

- Survey findings are stronger, provide better support when actions are taken	93%
- Survey findings relate more to patient care delivery	79%
- Duplication of IoC and survey effort eliminated or reduced	71
- Money saved from less travel	64
- Conflicts between survey and IoC findings have decreased	57
- Fewer staff needed	21
- Less time needed to survey due to availability of IoC findings	21
- Time savings permit greater allocation of resources to problem facilities	21

- Other: (Examples of responses)
    - + Standardized interpretation and application of regulations; reports are more reliable, etc.
    - + Minimization of providers playing one State agency against the other
    - + Reduce disruption to the facility
    - + Greater flexibility in scheduling
    - + Greater flexibility for staff to delve into problem areas and standards of practice

o Deficiencies cited since implementation of an integrated process have changed in the following ways:

- Number of deficiencies increased	50%
- More serious deficiencies	50
- No change in deficiencies	17
- Other: (Examples of Responses)	17

- + Change in deficiency types

GENERAL AREAS

BOTH NONINTEGRATED AND INTEGRATED STATES:

o Responsiveness of facilities to IoC findings in comparison to survey findings:

- Integrated	100%
- Nonintegrated	88

o Improvements noted during IoC followups and during the next visit:

- Forty-three percent of the 49 responding States are very positive that improvements do take place during IoC followups and during the next visit (e.g., medication errors, treatment of decubitus, recording of the treatment and progress, etc.)

- State feels it could carry out an effective IoC program, if sampling were permitted:

  - YES * 59%

    Typical comments:

    - Sampling is sufficient to determine the type of care patients are receiving in a facility.
    - Surveyors can detect problems after reviewing a 10-20% sample.
    - Sampling is acceptable as long as the recipient remains in the same facility and stays at the same level of care.
    - States should be able to perform 100% review when they feel it is necessary.
    - Either sampling of recipients within a faciliy or sampling by facility is preferred over the current 100%.

  - NO 41%

    Typical comments:

    - Significant problems could exist that would go undetected.
    - A review of only a sample does not produce an accurate feel for care received by patients.
    - The effectiveness of IoC would be greatly diminished.
    - Sampling might affect the cost effectiveness of IoC review.

- State Action -- To assure consistent interpretation of its IoC criteria:

  - Ninety-one percent of the 41 respnding States provide their reviewers with technical assistance to assure consistent interpretation of its IoC criteria. The most common forms are:

+ Orientation and in-service training	29%
+ Frequent staff meetings	27
+ Written policies and procedures	24
+ Monitoring of team while onsite	15

NONINTEGRATED STATES ONLY

- Do IoC staff and surveyors ever present conflicting findings:
  - YES 24%
    - Surveyors find procedural deficiencies; IoC does not find environmental problems (infection control)
    - Nursing care plans, staffing
  - OCCASIONALLY 17

INTEGRATED STATES ONLY

- State recommendations for those considering integrating the survey and IoC processes:
  - Involve the industry.
  - Assure that management sees the entire picture and knows what direction the program is to take. Directions must be clear cut and precise.
  - Allow adequate planning time.
  - Physically locate staff together under the same bureau.
  - Establish a committee (State/providers) during the planning stages.
  - Keep providers informed of progress in developing and implementing the integrated system.
  - Review other State systems.
  - Provide adequate training, involve all surveyors in both processes.
  - Meet with other integrated States to benefit from their experiences and discuss the advantages and disadvantages of integration.

Attachment 2-17

PROBLEM AREAS

BOTH INTEGRATED AND NONINTEGRATED STATES:

- o Surveyors' and IoC reviewers' experiences in communicating and working together:
    - Eighty-four percent of the 33 responding States have an excellent working relationship; mutual concerns are communicated effectively.
    - The remaining 15 percent of these States experience difficulty in their communication and working relationships. Examples of problems are as follows:
        - + Lack of mutual respect and misunderstanding of roles.
        - + Willing to work together only up to a certain point. One agency will not allow the other to perform tasks which are delegated to its agency. Both agencies fiercely guard their territories.
        - + Very little official coordination.
        - + Inadequate communication.
- o IoC team experiences difficulty obtaining historical IoC information to prepare for upcoming reviews.
    - One third of the States have difficulty in accessing historical IoC information for upcoming reviews.

INTEGRATED STATES ONLY:

- o Modifications made since integrated process was initiated:
    - Forms
    - Interview process streamlined; now interviews are geared to disciplines
    - One State made an addition of key indicators.

Attachment 3-1

Comparison of Inspections of Care (IoC) and Surveys in LTC Facilities

Characteristic	IoC (MR/IPR)	Survey
References	Soc. Sec. Act 1902(a)(26) (B), (C); (31)(B), (C) 1903(g)(1)(D) Regs. Part 456 Subpart I 456.600-614	Soc. Sec. Act 1864 Regs. Part 405 Subpart S 405.1901-19
Team Comparison	RNs and SWs	RNs, SWs sometimes and others
Training	Varies by State	National training program
Patient Services Evaluated by Both Teams (Using Different Methods)	Utilization Review Medical Evaluation and Plan of Care (PCMS) Physician Services Nursing Services Dietetic Services Pharmaceutical Services Social Services Patient Activities Rehabilitation Services	Same
Standards for the Review of Patient Services	General regulations	Survey standards in regulations
	Interpretive guidelines being revised to include review procedure	Interpretive guidelines Survey procedures
Patient Sample Visited in Facility	Every Medicaid patient	Sample of patients

Characteristic	IoC (MR/IPR)	Survey
Determinations by Teams	Medical necessity of patient's continued stay at present level of care	
	Feasibility of meeting a patient's needs in an alternative setting	
	Evaluation of adequacy of the services rendered to each Medicaid patient	Evaluation of adequacy of the facility's patient services
Reporting Requirements	Specific findings about individual patients	
	Findings on the adequacy of a facility's services	Findings on the adequacy of a facility's services
	Reporting forms vary by State	Uniform National Reporting Form
Action on Report	Change in reimbursement to facility for patients whose level of care changed	
	Facility plan of correction required by some States, but not regs; no uniform timeframes for corrections	Facility Plan of Correction - 90 day correction limit
	May conduct follow-up visit to facility "promptly" for serious deficiencies; can be done by State Survey agency.	Follow-up visit to facility within 90 days for serious deficiencies.
	Referred to State Survey /Licensure agency for uncorrected or hazardous conditions	Decertification hearings or licensure sanctions

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date JUN 27 1984

From Director
Health Standards and Quality Bureau

Subject State Activity Plans and Budgets for Fiscal Year 1985--Amendment to Our May 22, 1984 Memorandum

To Regional Administrators
Regions I - X

Our May 22 memorandum concerning the subject plans and budgets did not address survey and certification activities with respect to the prospective payment system (PPS). The State survey agencies will continue to conduct annual onsite visits to determine if hospitals and units meet the requirements for exclusion from PPS.

Each State survey agency should include these visits in its activity plans; these visits are to receive the same priority and emphasis as initial certifications. Sufficient funds have been provided to accomplish these activities.

Should additional information concerning this matter be needed, please have your staff contact Margaret VanAmringe on (FTS) 934-5547.

Philip Nathanson

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care
Financing Administration

Memorandum

Date MAY 22 1984

From Director
Health Standards and Quality Bureau

Subject Program Emphases and Regional Allocations for the Preparation of State Activity Plans and Budgets for Fiscal Year 1985

To Regional Administrators
Regions I-X

I. General:

At this time, each State survey agency should begin preparation of its request for Federal support of Title XVIII and Title XIX survey and certification activities for FY 1985. As in the past, central office is providing guidelines and program emphases which should be communicated to each State in order to provide direction and assistance in preparation of the budget submission.

The President's FY 1985 budget for Medicare survey activity before the Congress is $47,074,000, an increase of 24.9 percent over the $37,698,000 available in FY 1984. In FY 1985, the required level of Federal reimbursement for Medicaid survey activity has been targeted at $39,610,000. Since Congressional action has not taken place providing an appropriation, we must assume passage of the President's budget request. Of course, if Congress does not provide an appropriation by October 1, 1984, a continuing resolution will be provided which usually maintains the prior year funding level. Therefore, when approving States' budgets, you are to inform them that the approval is subject to revision.

In our effort to continually refine the Medicare facility survey resources allocation process, central office has implemented the process recommended by the regional task force dated September 1, 1983 (Attachment I). This methodology supports a regional budget allocation based on number of facilities to be surveyed multiplied by a dollar value based on aggregate surveyor time values. Facility counts utilized are those found in the most recent MMACS master file (4/84).

As recommended by the regional task force, requirements for indirect costs have been excluded from the regional allocation methodology. Based on FY 1984 budget data, we know that approximately 22.8 percent of total costs are indirect costs. This percentage was applied to the total funds available ($47,074,000) to determine the estimated amount of indirect costs States will incur ($11,192,000). This amount was then prorated among the regions based on each region's requirements for the negotiated rates assigned to their States. This action eliminates the penalty some regions incur as a result of inordinate State indirect cost rates.

Travel is another area that has been excluded from the regional allocation methodology. Based on FY 1984 budget data, we project $2,379,000 will be required for travel. This amount has been prorated among the regions to provide a more equitable share of resources since the geographic makeup of some regions requires longer (more expensive) travel requirements.

Regional targets for Medicaid are based on States' requirements from prior years, increased to take into account cost of living adjustments and initial surveys of facilities requesting participation. The annual target you approve for Medicaid is for planning purposes and is nonbinding. State provided quarterly estimated requirements and actual expenditures will be the final determinants for Medicaid funding.

Again, you will be required to establish specific survey plans for each State and track each State's performance against this plan by each type of facility -- for Title XVIII, XVIII/XIX, and XIX facilities. Survey counts will be monitored via the Regional Management System.

II. Program Emphases:

Survey activities for FY 1985 should be scheduled and conducted in accordance with national priorities. The priority ranking reflects program emphases and budget realities. Under current law, all long-term care facilities must be surveyed and certified annually. Sufficient funds have been provided to accomplish this requirement. Remaining Medicare funds are to be used for surveying non-long-term care facilities, subject to national priorities and budget limitations. Regional or State-specific problems may require some deviation from national priorities. However, top priority activities should not be curtailed. A priority listing for non-routine surveys follows.

1. Initial surveys: In order to participate in Medicare and/or Medicaid a provider or supplier must first be surveyed and found to meet all eligibility requirements. This means that inpatient facilities must have patients in the facility before the survey is conducted. Similarly, a supplier must be furnishing services before it can be surveyed. There are no exceptions to this rule. States are expected to set aside sufficient funds to complete these surveys.

2. Special surveys related to the initiation or processing of termination or other adverse action surveys.

3. Complaint surveys (all Medicare/Medicaid complaints relating to providers and suppliers).

4. Other providers and suppliers (priority according to compliance history and time elapsed since the last survey).

5. Validation of accredited hospitals.

Beyond considerations of the survey types mentioned above, further elaboration on survey purposes and procedures that should prove helpful during budget preparations are:

Size and Composition of Survey Team

State agencies in preparing their budget requests should assume that full survey teams will be funded.

Consultation

State agency consultation activities should be conducted by mail or phone contact to the maximum extent possible. Onsite consultation visits are to be determined by the severity of deficiencies.

Surveys Following Change of Ownership

As a general rule, surveys are not required immediately following a change in ownership since the provider agreement is automatically assigned to the successor owner. Also assigned is the existing plan of correction. When the survey agency believes a survey is necessary, it is better to make the visit several weeks after the change in ownership. At this time the effect on patient health and safety can best be evaluated.

Complaint Surveys

Medicare and Medicaid complaint investigations should be conducted as quickly as possible. An onsite visit will be necessary if the complaint alleges a serious threat to patient health or safety. If it can be determined that an onsite visit is not immediately necessary, a telephone call or letter should be used. The complaint should also be investigated during the next scheduled visit to the facility.

JCAH Validation Surveys

Validation surveys remain an important State responsibility. States must allocate sufficient resources to maintain their oversight of JCAH surveys.

Adverse Actions

In FY 1985, States will be expected to expedite certifications which provide the bases for termination action. When there is an immediate threat to patient health or safety, survey findings, statements of deficiencies, certification decisions and all supporting documentation will have to be prepared within short timeframes. States will have to ensure that they have the required resources to meet the demands of the accelerated process. The availability of sufficient clerical support will be essential.

Revisions to the Survey and Certification Process

It is likely that during FY 1985 certain rules in Subpart S will be revised. Central office will keep you apprised of these developments and provide you with the necessary direction for implementation of any changes to the current process.

III. Training:

This section provides training courses which will be given in FY 1985 by the Division of Survey Procedures and Training. This schedule should be considered by State and regional offices in developing and approving State agency training budgets for FY 1985. Professionals who have completed the basic courses are encouraged to attend specialty courses as appropriate.

BASIC SURVEYOR TRAINING COURSES (5 DAYS) WILL BE OFFERED AS FOLLOWS:

Basic Health Facility (6 Offerings)

All courses are scheduled for Baltimore except for two which are planned for New York State and Dallas, Texas.

PROGRAM FOCUS: The Basic Health Facility Surveyor Course is designed to provide the new State agency surveyor with the skills of data gathering, documentation, decisionmaking, and consultation as they relate to health facility surveying.

Basic Life Safety Code (2 Offerings)

Baltimore, Maryland

PROGRAM FOCUS: The Life Safety Code Training Course is designed to assist Life Safety Code surveyors to effectively perform fire safety surveys in health care facilities.

Basic Laboratory (1 Offering)

Atlanta, Georgia

PROGRAM FOCUS: The Basic Laboratory Survey Training Course is designed to provide a uniform understanding/interpretation/application of laboratory regulations and to provide a technical update to State agency surveyors and regional office consultants.

PRIMARY TARGET GROUP: All newly employed surveyors who have completed an orientation program and who have not previously participated in a basic surveyor training course.

SPECIALTY SURVEYOR TRAINING COURSES (2-3 DAYS) WILL BE OFFERED AS FOLLOWS:

Management Development Workshop (3 Offerings)

Baltimore, Maryand

PROGRAM FOCUS: The Management Development Workshop is designed to provide first-line and mid-level supervisors with the knowledge and skills needed to be effective managers within the Medicare/Medicaid programs.

PRIMARY TARGET GROUP: First-line and mid-level supervisor whose primary job responsibility includes the day-to-day management of the survey and certification process. Preference should be given to newly hired supervisors.

Surveying for Quality (2 Offerings)

Chicago, Illinois
Atlanta, Georgia

PROGRAM FOCUS: The Surveying for Quality course will focus on current information and preferred standards of practices indicating quality of care and supportable with current regulations.

PRIMARY TARGET GROUP: Surveyors with training and experience as a health care professional, e.g., nurse, dietitian, pharmacist, etc.

Interpretation and Application of Patient Care and Services Survey Tool (PACS) (5 Offerings)

Baltimore, Maryland
Atlanta, Georgia
Chicago, Illinois
Seattle, Washington
Dallas, Texas

PROGRAM FOCUS: This PACS course will focus on the proper utilization of the PACS instrument in the survey process.

PRIMARY TARGET GROUP: Surveyors who devote 50% or more of their time to the surveying of long-term care facilities.

Priority Survey and Certification Procedures Workshop (3 Offerings)

Baltimore, Maryland

PROGRAM FOCUS: This workshop is designed to assist regional office and State agency personnel to apply and interpret policies and procedures regarding adverse actions and any new survey and certification regulations (Subpart S).

PRIMARY TARGET FOCUS: Regional office and State agency personnel with primary responsibility for a major survey and certification activity.

ICF/MR (2 Offerings)

Denver, Colorado
Atlanta, Georgia

PROGRAM FOCUS: The course is designed to provide the generalist surveyor with information regarding developmental disabilities and surveying for the existence of active treatment. It will provide technical assistance in the interpretation and application of the Federal regulations.

PRIMARY TARGET GROUP: Surveyors with limited experience in surveying facilities for the mentally retarded.

Workshop to Develop Problem Oriented Training Courses
(2 Offerings)

Baltimore, Maryland
Denver, Colorado

PROGRAM FOCUS: This workshop will focus on course development utilizing various data sources in the regional offices and State agencies.

PRIMARY TARGET GROUP: State trainers and coordinators whose primary responsibility is to identify training needs of survey and certification personnel.

EQUIPMENT

In addition to these courses, consideration should be given to purchasing equipment (such as microcomputers, video cassette recorders, and slide projectors) to support and utilize newly developed training modules.

Training costs should be reported as an exclusive budget line item. In your instructions to the States, please remind them that this is a restricted line item and may not be rebudgeted without prior written approval from the regional office.

IV. Financial Management Guidelines:

The State Operations Manual (SOM), Part IV Administration and Financial Management is the technical guide to be used in the preparation of the State's FY 1985 budget submittal. Section 4010ff, "The Annual Activity Plan," should be carefully reviewed and followed in conjunction with this letter. Part III of the Regional Office Manual (ROM) contains information relevant to the budgetary process with regard to regional office requirements. Both manuals were recently revised (refer to SOM and ROM transmittal documentation dated December 1983) to provide improved direction for State submittal of budget requests and regional office approval for both long-term care and non-long-term care survey activity. Federal Management Circular No. A-87, "Cost

[Facsimile of HCFA Memorandum received in illegible condition.]

DEPARTMENT OF HEALTH AND HUMAN SERVICES

AUG 9 1984

[From] Director
Health Standards and Quality Bureau

[Subject] Time Limited Agreements

[To] Associate Regional Administrators
Division of Health Standards and Quality
Regions I - X

Reports of recent ROPES [Regional Office Performance Evaluation Survey] findings indicate some inconsistency among Regions in implementing time limited agreements and other Subpart S requirements. As I noted in my January 27, 1983 memorandum (attached), the conditions under which we implemented interim policies for flexible survey cycles for long-term care facilities have changed.

It is clear that Congressional intent and the commitment of the Administration is to enforce the requirements of Subpart S. In my January 1983 memorandum, I noted that due to the logistical problems we would allow a liberal phase-in period for returning to full compliance with Subpart S. I would expect that by this time we would be in full compliance with all provisions. If you have not yet returned to full compliance, you should move aggressively toward that end.

Philip Nathanson

Attachment

cc: Director, OSC
Prepared by: HSQB/OD/TMorford:jgX71910:Doc No. 7779A 8/8/84

TAB K

DEPARTMENT OF HEALTH AND HUMAN SERVICES

[AUG 9 1984]

AUG 9 1984

Director
Health Standards and Quality Bureau

Time Limited Agreements

Associate Regional Administrators
Division of Health Standards and Quality
Regions I - X

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Philip Nathanson

Attachment

cc: Director, OSC
Prepared by: HSQB/OD/TMorford:ja771910:Doc No. 7773A 3/8/84

File
Copy

OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Region X
M/S 409
2901 Third Avenue
Seattle, WA 98121

September 6, 1984

Conrad A. Thompson, Director
Bureau of Nursing Home Affairs
Department of Social and Health Services
M/S OB-31
Olympia, Washington 98504

Dear Mr. Thompson:

We are enclosing a copy of State Operations Manual draft revisions to Sections 1200 and 4000. These instructions will revise current termination procedures for Medicare and Medicaid.

Please review these procedures and be prepared to implement them by October 15, 1984. Our Central Office has advised us these procedures will receive final clearance by that time and will be effective then. Your State Representative will be in touch with you concerning training you and your staff.

We will find it useful if you will telephone us with any questions you have about the procedures by September 20, 1984. In doing so, please consider whether our tentative view that the current State Latters 132 and 147 can remain relatively unchanged for Category I termination actions.

We have also enclosed copies of the Regional Office manual revisions for your information.

Sincerely,

Donald K. Jaques, Sr., Chief
Survey and Certification Operations Branch
Division of Health Standards and Quality

Enclosures

RECEIVED
SEP 10 1984

[COMMITTEE STAFF NOTE: This is an excerpt of the Draft Termination Procedures sent out to the States and Regions in September 1984.]

DRAFT

New Material	Page No.	Replaced Pages
Table of Contents, Part 3	3-1 (1 p.)	
Sections 3000-3070 (Cont'd)	3-3 - 3-25 (23 pp.)	
Table of Contents, Part 5	5-3 - 5-6 (4 pp.)	
Exhibit 46	5-179 (1pp)	
Exhibits 48 - 50	5-183 - 5-190 (8 pp.)	

This material restructures State Operations Manual instructions on initial provider and supplier denials, terminations, nonrenewals and cancellations of time-limited agreements, reconsiderations and hearings, and on readmissions to the Medicare and Medicaid programs after termination, nonrenewal or cancellation. The material is prepared for inclusion in a forthcoming general revision of the SOM; sections and pages do not match the parallel sections and pages of the SOM in its present revision. The material in its entirety compares to present SOM [illegible]2. Only those portions substantively changed have been bracketed.

The following procedures are substantively modified or are new:

Section 3000, Initial Denials.--Subsection B instructs State agencies to forward to the RO records on identified providers or suppliers where, through disinterest, insufficient information was furnished to complete a certification.

Section 3010, Basis for Terminating.--Subsection D discusses timing considerations in choosing whether to document a long-term care case for termination, nonrenewal, or cancellation. Subsection F outlines the prerogative of HCFA to terminate based on direct Federal surveys.

Section 3020, Termination Procedures.--Detailed termination time schedules are provided. There are two schedules; their use depends on whether or not termination must be prosecuted urgently because of the discovery of situations that imminently jeopardize the health and safety of patients. Examples of such situations are given. Subsection E explains the circumstances under which the schedules may be varied. Only regained compliance warrants an interruption of termination action. Neither partial progress on corrections nor, as explained in subsection F, an intervening change of ownership warrant interrupting the termination action.

Section 3030, Nonrenewal of Time-limited Agreements.--This section clarifies that nonrenewal may be justified by persistent failure to make corrections even though the deficiencies did not jeopardize health and safety or substantially limit the provider's ability to render adequate care. However, there would be justification to renew if the provider did correct and the deficiencies later recurred due to conditions beyond the provider's contol.

Section 3034, Cancellation of Time-limited Agreements.--This section points out that where a cancellation clause had made the provider agreement conditional upon the correction of deficiencies, cancellation may be invoked solely because of the persistence of these deficiencies as of the cancellation date, without the need to document compliance with the remainder of the standards.

Section 3070, Readmission to the Program After Involuntary Termination or Nonrenewal/Cancellation of Provider Agreement.--This section gives instructions for the State agency to ascertain when a provider reestablished compliance after a hiatus of a time period which is determined by the RO, and that it can again be certified.

Exhibit 47, Model Special Determination of Medicare/Medicaid Involuntary Termination.--Deleted.

Exhibit 48, Model Letter Notifying Medicare/Medicaid Facilities of Involuntary Termination of Provider Agreement.--Editorial changes are made to this exhibit.

Exhibit 49, Model Public Notification of Medicare/Medicaid Termination of Provider Agreement.--Editorial changes only.

Exhibit 50, State Agency's Letter to Medicare/Medicaid Facilities Seeking Readmission After Involuntary Termination.--This exhibit is revised to reflect new procedures for readmission following involuntary termination.

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cc Peggy Brown

DRAFT

New Material	Page No.	Replaced Pages
Table of Contents, Chapter 1	1-1 -1-2 (2 pp.)	1-1 - 1-2 (2 pp.)
Sections 1200-1225	1-71 - 1-73 (3 pp.)	1-71 - 1-77 (7 pp.)
Table of Contents, Chapter 4	4-1 - 4-2.1 (3 pp.)	4-1 4-2 (2 pp.)
Sections 4000-4351	4-3 - 4-28.2 (28 pp.)	4-3 - 4-30 (28 pp.)
Section 4660.1-4670	4-41 - 4-42 (2 pp.)	4-41 - 4-42 (2 pp.)
Table of Contents	6-1 - 6-2 (2pp.)	6-1 - 6-2 (2pp.)
Chapter 6	6-5 - 6-6 (2pp.)	6-5 - 6-6 (2pp.)
Exhibits 4-32 - 4-44	6-65	6-65 - 6-88 (24 pp.)
Exhibit 4-97 (Cont.)	6-189 - 6-190.3 (5 pp.)	6-189 (1 pg.)

Material on HCFA's authority under section 1910(c) and 42 CFR 442.30 to "look behind" a Medicaid-only provider's approval and either reverse that approval or determine that Federal financial participation will be reduced because the approval was procedurally in error, has been updated. Material formerly appearing in sections 1203-1225 has been merged with the chapter on adverse actions.

Procedures to be followed when termination action is required have been revised, expanded, and clarified.

Section 1200, Look Behind Authority of HCFA.--Editorial changes only.

Section 1201, Medicaid State Agency Disagrees with State Survey Agency Determination.--This section is added to explain that if the Medicaid State agency believes that the State survey agency's certification action is erroneous, it should contact the HSQ-RO to facilitate a resolution.

Section 1202, Monitoring Responsibilities of the HSQ-RO.--This section is added to include specific areas of RO responsibility for monitoring State agency activities attendant on the issuance of Medicaid agreements.

Section 4000, Denial Notices.--Editorial changes only.

Section 4100, Authority to Terminate Medicare and Medicaid Participation.--This section is revised to include "look behind" authority, editorial changes, and clarification that compliance may not be certified when conditions of participation are not met.

Section 4100A, Noncompliance with Conditions of Participation or Coverage.--This section is revised to clarify that a provider's/supplier's compliance cannot be certified based on a plan of correction.

Section 4100B, Violation of Provider Agreements, PRO Sanctions, Program Abuse, etc.—Editorial changes only.

Section 4100C, "Look Behind" Cancellation of Medicaid Eligibility.—This section is added to reference adverse action based on statutory look behind authority.

Section 4101, Termination Procedures.—This section has been added. It specifies procedures and processing timeframes which must be followed when it is determined that a provider or supplier should be terminated. The section requires that one of two termination procedures be followed depending on the nature and effect of the deficiencies.

Section 4101A, Noncompliance with One or More Conditions of Participation or Coverage and the Deficiencies, Alone or in Combination, Pose an Immediate or Serious Threat to Patient Health or Safety.—This section provides procedures which must be followed when the State agency or HCFA finds that cited deficiencies pose an immediate or serious threat to patient health or safety. Also included are criteria to be applied in determining whether an immediate or serious threat exists. This section clarifies the responsibilities of the HCFA and the State agency in processing this type of termination. These procedures should be applied only when there is a clearly documented threat to patients and expert testimony is available to support that finding.

Section 4101B, Failure to Meet One or More Conditions of Participation or Coverage and HCFA or SA Determines that Cited Deficiencies Alone or in Combination, Limit the Provider's/Supplier's Capacity to Furnish an Adequate Level or Quality of Care or Services.—This section provides procedures to be followed where termination action is required but the deficiencies do not pose an immediate threat to patients. This procedure reflects the lesser impact on patients by allowing, procedurally, the provider or supplier more time to achieve compliance with the Conditions. However, this section clarifies that a plan to correct is neither requested nor a substitute for compliance.

Section 4101D, Termination Action Based on Onsite Federal Survey.— This section is added to require that termination action be initiated and developed by the HSQ-RO when a Federal survey team determines during an onsite survey that deficiencies pose an immediate or serious threat to patient health or safety.

State agency - lic authority - Feds call in state agency -

Section 4102. Regional Office Clearance Procedure-Noncompliance with the Conditions of Participation or Coverage.--This section is revised both editorially and substantively. Revisions clarify longstanding interpretations and policies and conform these procedures to the procedures included in Section 4101.

Section 4103. Failure or Refusal to Disclose Ownership and Control Interest Information.--Editorial changes only.

Section 4104. Documentation Guide List-Noncompliance with the Conditions of Participation or Coverage.--This section is revised to clarify that: (1) the provider's/supplier's opportunity to correct falls between the citation of deficiencies and the effective date of termination, i.e., a plan to correct is not required to document "opportunity;" (2) consultation by the State agency consists of notifying the provider/supplier of the requirements and what might be done to achieve compliance; and (3) that termination action may be taken whether or not there is an adverse effect on patient health or safety.

Section 4105. Preparing the Special Determination-Noncompliance with the Conditions of Participation or Coverage.--This section and requirement has been deleted.

Section 4106. Documentation Guide List - Terminations for Noncompliance with Section 1866(b)(2)(A) and (C).--This section has been deleted because the HSQ-RO is not the component responsible for documenting these kinds of adverse actions.

Section 4107. Provider Agreement Terminations-Violation of Section 1866(b)(2)(A) and (C)-Forwarding Cases to Central Office.--Editorial changes only.

Section 4108. Central Office Actions-Violation of Section 1866(b)(2)(A) and (C).--This section has been revised to eliminate many types of terminations not processed by the HSQ-RO.

Section 4110E. Public Notice - Involuntary Termination for Home Health Agencies.--This section was revised by Section 2348 of the Deficit Reduction Act of 1984. Payments to home health agencies following termination will be limited to 30 days following the effective date of termination.

Section 4117. Billing After Provider Termination or Cancellation.--Editorial changes only.

Section 4118. Rescinding or Postponing the Effective Date of Termination-Conditions of Participation or Coverage.--This section is revised to include criteria for rescinding or postponing termination. Also included are criteria to be applied to determine whether an allegation of correction is credible.

Section 4120, Readmission to Program After Involuntary Termination, Cancellation, or Nonrenewal of Provider Agreement, or for Suppliers-Termination of Participation.—This section is added to define reasonable assurance, a provision which will be applied to ensure that the cause for termination will not recur. This section requires documented and ongoing compliance for varying periods, depending upon the nature of the deficiencies and the provider's and facility's compliance history. Also, included are special procedures to be followed when termination action pursuant to section 4230 (Look Behind) is taken.

Section 4125, Readmission Following Voluntary Withdrawal from Program Participation.—This section is added to clarify that voluntary withdrawal from the program following the initiation of termination action will not exempt the provider or supplier from the readmission restrictions imposed following termination action.

Section 4200, Special Considerations in Terminating Time Limited Agreements.--Editorial changes only.

Section 4202, Cancellation Clause-RO Processing Documentation for Health and Safety Findings.—Editorial changes only.

Section 4206, Nonrenewal of Time-Limited Agreement.—This section contains some minor technical and editorial changes to clarify that deficiencies are not required to have an immediate adverse effect on patients to cause nonrenewal of the agreement.

Section 4213, State Agency Intermediary Notices.—Editorial changes only.

Section 4215, Provider Allegation of Correction.--This section is revised to include a cross reference to Section 4118 and other editorial changes.

Section 4230, Terminating Medicaid Provider Institution's Eligibility Based on "Look Behind" Determination.—This section contains a revision to clarify that termination action may be taken based on clear documentation that the provider is not in compliance with major program requirements. Also, included is a cross reference to Section 4101.

Section 4235, Disallowance of Federal Financial Participation (FFP) to a State Because the State Fails to Follow Correct Certification Procedures for Medicaid Provider.—This section contains minor revisions to clarify the necessary notices when a Medicaid provider agreement is considered invalid for FFP purposes.

Section 4351, Notification to the Carriers and Public that a Supplier Has Been Terminated.—Minor editorial changes.

Section 4660.1, Hearing on Section 1910(c) Cancellation of Medicaid Eligibility.—This section contains a minor technical change to correct the address to which a provider's hearing request should be sent.

Exhibit 4-31, Supplier That Has Ceased or Is Ceasing Operations.—Editorial changes only.

Exhibit 4-32, Special Determination of Medicare Involuntary Termination.—Deleted.

Exhibit 4-33, Provider Not in Compliance with Conditions of Participation that has Submitted an Acceptable Plan of Correction.—Exhibit is deleted because it is inconsistent with procedures detailed elsewhere in this Part.

Exhibit 4-34, Notifying Provider of Pending Recommendation for Involuntary Termination.—This exhibit is revised to conform the letter to procedures found elsewhere in Section 4100ff.

Exhibit 4-35, Model Letter to Provider/Supplier Warning of Possible Termination.—Editorial changes only.

Exhibit 4-36, Notifying Previously Approved Supplier of a Pending Termination.--This model letter is revised to conform the letter to procedures found elsewhere in section 4100ff.

Exhibit 4-38, Notifying Provider of Involuntary Termination of Provider Agreement.—The model letter is revised to include the readmission restrictions, other editorial changes, and to remove reference to the Burleson Amendment.

Exhibit 4-39, Notifying Medicare Skilled Nursing Facility of Involuntary Termination of Provider Agreement.—This letter is revised to include the readmission restrictions and other editorial changes.

Exhibit 4-40, Notifying Previously Approved Laboratory of Partial Termination.—This model letter is revised to update organizational designations and addresses.

Exhibit 4-41, Notifying Previously Approved Supplier of Termination.--This model letter is revised to update organizational designations and addresses.

Exhibit 4-42, Notice of Nonrenewal of Agreement.--This model letter is revised to update organizational designations and other editorial changes.

Exhibit 4-43, Public Notification of Medicare Termination of Provider Agreement.--Editorial changes only.

Exhibit 4-44, Acknowledging Request for Hearing.—Editorial changes only.

Exhibit 4-97, (Continued), Model Letter Notifying Medicaid Skilled Nursing Facility of Cancellation of Approval of Eligibility to Participate.--A minor technical change is added to this exhibit to update the address to which a provider's hearing request should be sent.

Exhibit 4-97A, Preliminary Notice to Medicaid Provider of Cancellation of Approval of Eligibility to Participate. This model letter is added to provide not only policy guidance, but also the vehicle for meeting statutory notice requirements.

Exhibit 4-97B, Notice of Cancellation of Approval of Eligibility to Participate, Immediate or Serious Threat to Patients. This model letter is added to clarify procedures to be followed when, pursuant to section 1910(c), the RO determines that a provider's deficiencies pose an immediate or serious threat to patient health or safety.

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Sharon
Z.m's
CC's all sent

JOHN SPELLMAN
Governor

KAREN RAHM
Secretary

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Olympia, Washington 98504

send
CC's

September 27, 1984

Donald K. Jaques, Sr., Chief
Survey and Certification Operations Branch
Division of Health Standards and Quality
Region X, Mail Stop 409
2901 Third Avenue
Seattle, Washington 98121

Dear Mr. Jaques:

This letter is in response to your September 6, 1984 letter transmitting the revisions to State Operations Manual (SOM) Sections 1200-4000 and soliciting comments and questions by September 20, 1984. As discussed with you by phone on September 20, 1984, this letter will provide written notice of some of the major concerns of the State of Washington regarding the proposed termination procedures scheduled for implementation on October 15, 1984.

The State of Washington hereby officially requests that the implementation date of these termination procedures be delayed until such time as representatives of HCFA and state licensure/certification programs can meet together and resolve the many problems evident in the proposed procedures.

The proposed termination procedures are complex, confusing, and legally unsound and will have a major impact on the states and the long-term care industry. If implemented as scheduled, they will place a serious strain on both state and federal resources to the detriment of the Medicare/Medicaid programs.

Over the past several years, emphasis has been placed on "the federal-state partnership." Working in a cooperative, mutually-supportive effort, this partnership can do much to secure compliance with rules and regulations and to advance the quality of life for our nations' long term care residents. We strongly object to the fact that these termination procedures have been developed unilaterally at the federal/central office level with no input from the states. The federal-state partnership has broken down and as a result valuable insight has been lost.

The states have a clear interest and responsibility in certification issues and, collectively, they have years of legal experience and expertise dealing with certification/termination issues. Through precedential experience, the states have a working knowledge of what processes and procedures are effectual in actual practice.

After reviewing these proposed termination procedures, it is our professional judgment that these procedures are contradictory, open to broad interpretation, contrary to federal regulation, arbitrary, capricious, and generally ineffective. Their implementation would result in legal entanglements sufficient to obstruct the timely and effective intervention necessary to protect the health and safety of the clients served. The sections of this letter that follow outline some of the major shortcomings of the proposed procedures.

The termination procedures are sufficiently restrictive to remove the decision process out of the realm of surveyor judgment. As currently proposed, the procedures are self-serving and mechancial rather than allowing experienced professional judgment and flexibility to act in a manner which is in the best interest of the patients. It is axiomatic that decisions should be made at the lowest possible level.

The termination procedures include a variety of new, undefined terms which are not supported in federal regulation. Because these terms have no basis in regulation, and are not defined, they create serious problems. These undefined terms will lead to differences in interpretation, misinterpetation, misunderstanding and lack of uniformity of application among the state agencies. These problems will cause serious legal stumbling blocks in that adminstrative law judges, hearing officers, and the courts will have to be convinced by us of the meanings of the terms; and we will be forced to rely on subjective terms rather than objective facts. Examples of some of the terms include "immediate threat," "serious threat," "services of an adequate level or quality," "potential hazard," "unsolicited plans for correction," "early prospect of compliance," "credible allegation of compliance," "short form determination," "lock out," "credible evidence," and "reasonable assurance".

Many statements in the termination procedures are contrary to federal regulations. A few examples of this problem are:

Section 3020A states that "compliance may not be certified based on a plan of correction of the noncompliance or on a provider's progress in correcting the deficiencies." This statement is directly in conflict with federal regulations at 42CFR 405.1907(a), 42CFR 405.1908(a)(2), 42CFR 442.105(b), and 42CFR 442.111(c)(2).

Section 3020B states "do not use the HCFA-2567 to convey the statement of deficiencies to the providers ...." This is contrary to federal regulations, which require the use of official Office of Management and Budget (OMB) approved forms cited at 42CFR 431.610 (f)(1) and 42CFR 442.30(4).

Section 3010 E references "lock out" of Title XIX provider under 42CFR 431.53(f). Our review of the Code of Federal Regulations indicates that there is no paragraph (f) under 42CFR 431.53.

Many parts of the procedure clearly indicate that the provider is not to be allowed to submit a Plan of Correction if termination is being pursued. In the state of Washington, a decertification case was lost at the State Supreme Court level, due to this very issue. The Court ruled that the state erred in not obtaining a Plan of Correction and giving the provider the opportunity to achieve correction and compliance. While the Code of Federal Regulations does not specifically require a Plan of Correction in cases where there is an unmet condition, it is not prohibitive on the issue either. Most state administrative procedures acts and due process requirements will allow the provider to submit a Plan of Correction or other statement of response to a cited deficiency. We cannot take away this right to respond even though the Plan of Correction may not be acceptable for recertification purposes.

The termination procedures are written in a confusing unorganized manner. The procedures for Medicare providers and the procedures for Medicaid providers are intermingled to the extent that the reader cannot tell which applies in a given situation. Considering that we have been working with these program regulations for a combined total of over 50 years and we have had problems sorting out what process applies to what provider, you can imagine how confusing these procedures would be to the public, the providers, or an administrative law judge. The entire set of procedures must be re-written in clear, concise terms and must clearly delineate and differentiate the Medicare process from the Medicaid process.

The "fact sheet" referenced in Section 3026D will add considerable work and additional staff time to the processing of a termination packet and could cause a delay in timely completion. This fact sheet asks for information which is difficult to obtain with accuracy and which, ultimately, has no bearing on the true issue of patient health and safety or the ability to render adequate care. This information is already available from other federal resourses as follows:

- Item 1 on the sheet can be obtained from the Life Safety Code SRF and Crucial Data Extract.
- Item 2 is information available from the C & T form. Admission numbers are useless information for deciding the certifiability of the provider.
- Item 3 is available through the MMACS data base via the county code, city code, and data from tables relating to the Standard Metropolitan Statistical Area which is coded also in MMACS.
- Item 4 information is basically not necessary. Names and addresses of other providers in the service area is available through MMACS.

Surveyors are required to initiate sustainable terminations when conditions at facilities call for them. Inclusion of voluminous steps, information and documentation by the State Agency (SA) simply creates an array of opportunities for a provider to attack a termination procedure. Surveyor's should be required to supply and document only relevant information and should not be required to cite all applicable regulations. An analogy would be to require a policeman to list the passenger capacity and engine displacement of a vehicle before issuing a citation and to cite all applicable laws and regulations violated. Implementation of these requirements would create a severe bugetary impact and potentially increase the cost for termination actions by 50%.

The reliance on Time Limited Agreements and Automatic Cancellation Clauses causes a tremendous drain on scarce survey resources with no benefit. A Time Limited Agreement is an agreement that has a specific ending date. If no action is taken to continue or extend the agreement, it ends on that date. In order to continue the agreement, the survey agency must complete a full survey of the provider no more than 20 days, but no less than 60 days, prior to the certification ending date. This means that the provider (who knows what the ending date is) knows when the survey team is coming within a 60 day "window." This means the provider is prepared for the survey and the survey team may be surveying under "artificial" situations. In addition, this is in violation of Washington state law and federal policy which prohibit advance notice of a survey.

The primary problem with Time Limited Agreements is the loss of flexibility of the survey agency. We currently operate with open-ended certification periods which means that the certification can continue until there is an action to terminate it. The contract that the state enters into with the provider contains a clause that either party can terminate with 30 days written notice; the ultimate effect is that we do have a time limitation on the agreement. Under the open-ended contract, the state is free to set a given provider's survey frequency based upon degree of compliance achieved, compliance history, history of complaints, Inspection of Care findings, stability of key staff, and history of adequacy of corrective action. In other words, the state has the flexibility to be truly responsive to the situation. The "good" providers do not need to be surveyed as frequently as the "marginal" providers and, under Washington's system, they aren't.

Each provider receives at least an annual survey, but when it occurs and how often is based on compliance. The providers with problems are the ones that need close, frequent monitoring. Under the open-ended contract, the state can utilize its survey resources to do this close, frequent monitoring to the ultimate end that the patients' health and safety are protected. If we go back to Time Limited Agreements, each provider is seen on a pre-determined schedule regardless of how well or how poorly they comply with the regulations. The provider knows approximately when to expect the survey. Limited surveyor resources are depleted as there is no flexibility allowed in the survey schedule. The patients in the marginal homes are not adequately protected. This is a costly, inefficient, and ineffective system.

Automatic cancellation clauses have no effect. Washington state formally wrote agreements with automatic cancellation clauses but found that implimentation of this provision is still a legal termination action and due process legal requirements apply. There is nothing "automatic" about the concept, and it is required that we prove patient health and safety jeopardy before any termination action can be taken. The failure to correct deficiencies, taken by itself, is not sufficient grounds to cancel a contract absent proof of jeopardy and harm. The automatic concellation clause concept is well-intentioned, but it doesn't work in practice and should be discarded.

In Sections 3020D(3) and 3026C, the procedure clearly implies that a revisit is to occur only if the Regional Office directs that it be done. The need for a revisit can best be determined at the state survey agency level by staff most familiar with the provider, the compliance history and capacity to achieve correction. For those reasons, the conduct and timing of the revisit must be left to the state's discretion and judgment.

In addition, the state agency has authority and responsibility for licensure of the provider. For that reason, the state must be allowed to revisit whenever, and as often as needed. The state licensure agency would be guilty of nonfeasance if it did not conduct appropriate follow-up visits to assure patient health and safety. Requiring that revisits be conducted only at the request of, or with the approval of the Federal regional office is an unwarranted intrusion of Federal authority into states' rights.

Section 3020C lists some examples of situations that constitute an "immediate or serious threat to patient health or safety." This section goes on to explain the timeline for action in such cases and allows 40 days for the termination action to occur.

We agree that some of the examples shown constitute an immediate threat. In those cases, the state of Washington currently uses the term "immediate." Immediate threat to us means there is a problem of such severity and/or magnitude that is must be resolved immediately. This requires immediate removal of patients. In such cases, we cannot allow 40 days to pass. Once we identify the problem we are legally bound to insure action sufficient to protect the patients from harm. To identify the problem as an "immediate threat" and then to walk away and do nothing further makes the state culpable and liable, should further harm occur.

Some of the examples obviously do not meet this narrow definition of "immediate." As always, the only person in position to judge the severity and immediacy of threat is the professional surveyor on site. That is the person we rely upon to tell us what is wrong and how serious it is. We cannot rely on a list of examples or "critical" regulations to make those professional judgment decisions for us.

With Section 1200 procedure, "look behind" authority is expanded to include termination of the Medicaid provider certification by the RO when the RO finds the provider to be out of compliance either through a federal on-site survey or review of the state agency survey findings. The provisions can open the door for serious conflicts between the provider, the federal RO and the state agency, and increased legal challenges by the provider.

The "Look Behind" provision indentified under Sectons 1200 and 4235 permit federal disallowance of payments based on paper compliance rather than threat to patient elath and safety or the providers inability to render adequate care. Such an action would likely be viewed as arbitrary and capricious and disallowed in the courts.

This look behind provision has not defined what "procedures" would be just cause for disallowance of FFP. Why should the provider and patient be penalized for the State Agencies alledged failure to properly follow federal procedures or properly complete federal forms. Should not this and other Federal guidelines focus on what is best for the patient?

At the present time, consistency in determining when a provider is not certifiable is somewhat maintained. The state agency determines the Medicaid certification while the RO determines certification for Medicare based on the state agency's survey findings and subsequent recommendations.

To increase consistency and uniformity in deciding certification and termination actions, the state agency should be held responsible for making decisions for Medicare and Medicaid. The RO could then allocate their time and resources conducting validation surveys, look behind, reviewing both Medicare and Medicaid certification decisions and using the findings to provide the state agency with consultation and training aimed at improving the survey skills of state agency staff.

Section 1202 C. Complaint Investigations procedure requires RO's to assume full responsibility to investigate complaints received for Medcaid only facilities. This is duplicative of the state regulatory agency as required by state law, the ombudsman's office as designated by the Older American Act and state law, and any referral agency if licensure of individuals are involved. It is unclear why the responsibility is shifted to the federal regions and further fragments the investigative process.

In Section 3070 the examples used to describe how to apply the concept "reasonable assurance" after an involuntary termination, allow for a wide range of time periods (30 days, up to one year) before readmission to the Medicare or Medicaid program. The effect of the examples is that they established criteria for readmissions which would create problems for the state agency and negatively impacts the welfare of the long term care patient.

In Washington State, the average occupancy rate of nursing homes is about 97 percent. Relocation of nursing home patients because of involuntary termination is a tremendous problem. With these criteria, patients would have to be relocated long distances away from family or significant others. With a high occupancy rate, a 30 day period for relocation is also insufficient. Eventually, the provider is allowed to be accepted back into the program, making the relocation efforts moot.

The state agency needs to have flexibility in applying the reasonable assurance concept. With those providers who demonstrate repeated violations, other sanctions may need to be considered such as civil fines, stop placement of patient admissions, stop payment or not allowing the provider to re-enter the program.

Section 3010E references termination of ICF's and ICF/MR's in those cases of non-compliance with standards. The ICF/MR regulations contain a great number of single line standards that have no elements under them. It is possible to be out of compliance with that particular regulation but not to the extent that the standard is not met. Under the current format, we are forced to show the standard not met to cite the deficiency. There needs to be a way developed to cite against these type of standards but still show the standards met. Such non-compliant cases would not be serious enough to mark the standard not met and would not warrant termination.

The instructions are not consistent regarding notification of the SA or RO regarding adverse action. States are required to keep RO informed but there is no obligation on the part of the RO to keep the SA informed. This will lead to lack of coordination, ill-feeling, wasteful duplication of effort and confusion.

In summary, we feel that there are far too many serious problems with these proposed termination procedures to implement them on October 15, 1984. We reiterate our request to delay implementation until such time as these problems can be resolved by joint meetings of federal and state officials. We certainly applaud the effort to create uniform procedures and intermediate sanctions, but we feel this current set of procedures will cause serious problems for HCFA and each state survey agency as they will not serve in the best interest of the patients. We stand ready to meet with you or other federal officials at any time. Help us to restore the federal-state partnership to the mutual benefit of patients and the program.

Sincerely,

Sharon L. Morrison
Sharon L. Morrison, Manager Survey Program

Mike Jessup, Manager Eastern Survey Program

Don Gatterman
Don Gatterman, Manager Southwestern Survey Program

Mary Z Crosby
Mary Crosby, Manager Northwestern Survey Program

Ann E Maioriello
Ann Maioriello, Manager IMR Survey Program

Darlene Aanderud
Darlene Aanderud, Manager and Chairperson
Program Integrity Unit. Compliance Enforcement
Committee

SM:jl

cc: Conrad Thompson
Tom Wallner
John Stilz
Gerald Reilly
Peggy Brown

VICTOR ATIYEH
GOVERNOR

Department of Human Resources
HEALTH DIVISION
1400 S.W. 5th AVENUE, PORTLAND, OREGON 97201 PHONE

October 2, 1984

Ms. Margaret VanAmringe, Director
Office of Survey and Certification
Health Standards and Quality Bureau
1849 Gwynn Oak Avenue
Baltimore, Maryland 21207

Dear Ms. VanAmringe:

I am writing to express my concern about the State Operations Manual draft revisions to sections 1200 and 4000 ie., termination procedures for Medicare and Medicaid.

I would like to request that these revisions be held in abeyance to allow time for comments from the State Licensing and Certification Agencies. If this extension is granted, I am sure that we can develop a more workable set of procedures.

Thank you for your consideration of this matter.

Sincerely,

Michael Patterson, Manager
Health Facilities Section
Office of Environment and Health Systems

MP:cv

cc: Tom Wallner
    Robert Dicenso

R
OCT 9 1985

Conrad
Thompson

STATE OF IDAHO
DEPARTMENT OF HEALTH AND WELFARE
FACILITY STANDARDS PROGRAM
420 West Washington
Boise, Idaho 83720-9990 (208) 334-4169

October 9, 1984

Margaret VanAmringe, Director
Office of Survey and Certification
Health Standards & Quality Bureau
Health Care Financing Administration
Department of Health & Human Services
1849 Gwynn Oak Avenue
Baltimore, Maryland 21207

This office received notification dated September 6, 1984, from the Seattle Region X office that revised Sections 1200 and 4000 of the **State Operations Manual** (SOM), **Termination Procedures**, were to be implemented by **October 15, 1984.** The revisions were enclosed. Unfortunately, other priorities at the state level often prohibit immediate review of such voluminous documents and this was certainly the case for Idaho when the packet was received. Nonetheless, I apologize for the delay in sending this letter to you since we firmly believe that there is some urgency to the request we are making.

First, we recognize that the central office of HCFA is presently updating and revising the SOM. The project we know is a difficult one and input from state agencies may not always be possible for each procedural change nor is it necessary in all cases. There are, however, certain procedures that carry such impact upon the state agencies and providers that revision in isolation of those affected is neither reasonable nor practical. The Termination Procedures which also include "Look Behind" procedures and Time-Limited Agreements fall in this category. For this reason we feel that the opportunity to review the proposed changes should have been given to the entities affected. The state-federal working relationship seems to have been totally ignored in a situation which calls for a significantly closer cooperative endeavor.

Secondly, the proposed Termination Procedures were found to be confusing, arbitrary, and without a legal basis in some instances. They are open to broad interpretation and subjectivity in some areas and totally inflexible in others. We found them to be difficult to follow which would naturally result in difficulty in application. In addition, the substantive changes will have a serious impact upon the state agency operations as they are presently funded and planned.

I have had the opportunity to discuss the proposal with representatives of the Oregon and Washington state agencies who fully agree with these observations. I have read Mr. Conrad Thompson's letter to you dated September 27, 1984, and support his comments.

Based upon the observations and concerns, we are requesting that implementation of the proposed Termination Procedures be delayed until all state agencies have the opportunity to review them and provide comments to you. This also makes one wonder at the appropriateness of continuing the planned expensive and time-consuming workshops for Termination Procedures. Two people from Idaho are scheduled for the Los Angeles workshop on October 29-30, 1984.

Your attention to the concerns expressed herein and by others is appreciated. We are most willing to provide whatever additional information you need to effect an improved procedure. Thank you.

Jean Schoonover

Jean Schoonover, R.N.
Program Manager

JS/nh

cc: Tom Wallner
Bee Biggs, R.N.
Robert DiCenso

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Zone [illegible]

Region X
M/S 409
2901 Third Avenue
Seattle, WA 98121

October 12, 1984

Conrad A. Thompson, Director
Bureau of Nursing Home Affairs
Department of Social and Health Services
M/S OB-31
Olympia, Washington 98504

Dear Mr. Thompson:

Thank you for your comments on the revised termination procedures. Clearly, you all put considerable effort into your review.

I am sharing your letter with our HSQB Director, Phil Nathanson, so that he and his staff have the benefit of your views before the Revised Termination Procedures Workshop in Los Angeles on November 7-8. Additionally, I am asking that the training team address your concerns during their presentation.

As I said during our telephone conversation on September 20, Mr. Nathanson directed all Regional Offices to inform State Agencies to implement these new procedures October 15, 1984. While you certainly raised some important points, we are not able to "set aside" the effective date as you requested.

I would hasten to add, though, that our Central Office is impressed with the aggressive approach taken in our locally developed SA and RO termination procedures. Thus, I am confident a reasonable approach will be taken to "converting" from what we developed to the new procedure.

Again, I appreciate the thoroughness of your review and comments.

Sincerely,

Donald K. Jaques, Sr., Chief
Survey and Certification Operations Branch
Division of Health Standards and Quality

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Health Standards and Quality Bureau
1849 Gwynn Oak Avenue
Baltimore, Maryland 21207

OCT 18 1984

Dear Participant:

Due to delays in the issuance of the final policy, dates for the Revised Termination Procedures Workshop have been changed. The revised dates are:

November 7-8, 1984

Holiday Inn Downtown
750 Garland Avenue at 8th Street & Harbor Freeway
Los Angeles, California

We apologize for the inconvenience these changes may have caused you. If you have any questions regarding these changes, please call Ms. Carol Horton at (301) 594-3212 or FTS 934-3212.

Sincerely yours,

Walter Merten, Director
Division of Survey Procedures
and Training

MEMORANDUM

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
REGION V — CHICAGO

TO : All Staff
Survey and Certification Operation Branch

DATE: 19 October 1984

FROM : Associate Regional Administrator
Division of Health Standard & Quality

SUBJECT Expedited Processing of Long Term Care Recertifications

All Long Term Care (LTC) recertifications are now being entered into MMACS immediately after receipt at the mail desk. The main benefit of this procedure is to eliminate review of those recertifications received from the State Agencies which have few or no deficiencies, thereby enabling us to concentrate SCOB efforts on problem cases. This procedure will also facilitate a consistent, professional monitoring of both Medicaid and Medicare facilities.

The LTC recertifications will be input into MMACS by the certification clerks, after which a MMACS Table 13 "Individual Facility Profile" (IFP), will be generated for each case. Using the critical element-control sheet, copy attached, as a screening device, the certification clerks will identify the critical elements which are not met, on both the IFP and the critical element/control sheet, and determine whether the cases are routine recertifications or problem cases. The routine cases will be certified by the certification clerks and filed by the secretaries with no additional review. In the first week during which the procedure was implemented approximately 70 to 75 percent of the LTC Recertifications received fell into this catgory and required no professional review.

Problem cases Reviewed by SCOB

The following criteria will be used to identify SNF problem cases:

(1) Two or more critical elements (on the critical element/control sheet) under one condition of participation are not met.

(2) A Total of six critical elements are not met.

(3) Any condition of participation or statutory requirement is not met.

Any ICF Which has six or more critical elements not met will also be considered a problem case for professional review by SCOB.

"ENERGYWISE ECONOMIZE"

Action Taken by SCOB on Problem Cases

The critical elements/control sheet will be maintained by the secretaries. The IFP's showing the critical elements that are not met, together with the rest of the recertification material and the file, will be given to the State teams by the secretaries. The State team will review these cases, all of which represent potential adverse actions, and take on [illegible] more of the following actions:

(1) Immediate termination under the revised termination procedures (SOM 3000 and ROM 4100) in those situations where the deficiencies pose an immediate or serious threat to patients' health and safety as described in SOM 3020 C.

(2) Termination where SCOB's review indicates that one or more conditions of participation are not met.

(3) Cancellation of the provider agreement .

(4) Denial of FFP under old or new "Look Behind" authority.

(5) Provision of a short term agreement or automatic cancellation clause.

(6) Recontact with the State agency for additional information and/or verification that the deficiencies have been corrected.

(7) Update MMACS data, if necessary.

After all actions have been taken by SCOB, the final disposition of the case and the date of the last action should be entered in the appropriate space on the critical element/control sheet. If the decision is made to recertify the case the rationale for such decision must also be shown.

A staff meeting to discuss this procedure will be held on October 19 at 2:00 P.M. in the SCOB work area.

Robert A. Cullen

Robert A. Cullen

Attachment

Termination procedures

JOHN SPELLMAN
Governor

KAREN RAHM
Secretary

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Olympia, Washington 98504

November 6, 1984

Margaret VanAmringe, Director
Office of Survey and Certification
DHHS, HCFA
Health Standards and Quality Bureau
1849 Gwynn Oak Avenue
Baltimore, Maryland 21207

Dear Ms. VanAmringe:

We received the redraft of the proposed termination procedures and appreciate the opportunity to comment on them. I commend the decision of the Health Care Financing Administration to cancel the implementation of the proposed termination procedures and scheduled training.

The redrafted termination procedures were reviewed by survey and operations compliance enforcement staff of the bureau, a physician from the Division of Medical Assistance and a representative from the state Attorney General's office. Their comments, which are enclosed, find that the procedures still contain major deficiencies.

There are two aspects to the termination procedures, which deserve further comment. First, intermediate sanctions, provided for in the Omnibus Reconciliation Act, are not included in the procedures. They should be. Intermediate sanctions are a critical component of the regulatory process. The ability to stop admissions of Medicaid and Medicare patients is the most effective tool for assuring the protection of patients and timely correction of deficiencies. There should be a provision for civil fines.

The second aspect is the Reasonable Assurance concept. This concept portends the most serious consequences for Medicaid and Medicare patients. To preclude provider participation in Medicaid or Medicare for short periods of time, less than one year, is detrimental to patients and punishes the wrong party. It will prove profoundly disruptive to effective administration and will not serve the best interests of patients. It is my most urgent request that this concept of Reasonable Assurance be carefully re-evaluated and a sensible policy be developed.

I understand that Mr. Lou Remily, President of the Association of Health Facility Licensure and Certification Directors, will be in contact with you soon. Perhaps, you and he could discuss how the Association may be of assistance to you in establishing effective termination procedures. If a work group is established to achieve this end, the inclusion of consumer and industry representatives on such a work group merits consideration.

We welcome the opportunity to work with you to assure our mutual goal of quality patient care. Please call (206) 753-5840 if we may be of assistance.

Yours truly,

Conrad Thompson
Conrad Thompson, Director
Bureau of Nursing Home Affairs

CT:sc

Enclosure

cc: Lou Remily
Gerald Reilly
Joseph Anderson
Jean Schoonover
Peggy Brown
Wesley Brock
Sharon Morrison

ANALYSIS OF DRAFT REVISION TO STATE OPERATIONS MANUAL

The October 26, 1984 revised draft of the State Operations Manual (SOM) termination procedures have been studied by staff of the Bureau of Nursing Home Affairs, the Division of Medical Assistance and the Office of the Attorney General of the state of Washington. The resulting analysis comments on strengths and weaknesses of the revised draft and includes suggestions and proposals. Several sections of the September 27, 1984 response letter to the original SOM proposal are also included. These sections remain concerns and remain unresolved in the latest revision.

We clearly support the need for clarification and delineation of federal and state roles, and responsibilities for Medicare actions. Such clarification will augment uniformity of expectation and action among the ten regional offices and all states.

The concept of global directions relative to Medicaid actions is supported, but it is strongly maintained that the actual mechanism of action and the supporting of professional judgments and decisions is best served by the state agencies.

The states have a clear interest and responsibility in certification issues and collectively have years of legal experience and expertise dealing with certification/termination issues. Through precedential experience, the states have a working knowledge of what processes and procedures are effectual in actual practice.

The comments on Sections 1200 and 4253 regarding "Look Behind" and on the complaint investigation section (Washington State's September 27, 1984 review of draft SOM revisions) remain as concerns. This latest SOM revision did not include these portions; it is unknown if these sections were modified or not.

The revised SOM sections are somewhat improved compared to the original version; however, it remains our professional judgment that these procedures are contradictory and open to broad interpretation. Their implementation would result in legal entanglements sufficient to obstruct the timely and effective intervention necessary to protect the health and safety of the clients served. Examples of our concerns follow:

INTERMEDIATE SANCTIONS:

We strongly support the need to develop intermediate sanctions in the Medicare/Medicaid programs. This encourages the provider to secure compliance with rules and regulations and to advance the quality of life for our nation's long term care patients. The use of intermediate sanctions, prior to implementation of program termination, clearly best serves the interest of the patients.

The Omnibus Reconciliation Act (PL 96-499) of 1981 gave the Secretary of DHHS authority to impose intermediate sanctions to providers who were substantially out of compliance but did not have deficiencies that immediately jeopardized the health and safety of the patients. An intermediate sanction that has been most effective under these circumstances in Washington State is the stop placement of all patient admissions.

Stop placement is effective because it:

- Assures protection of patients.
- Does not require relocation of patients already in the nursing home.
- Assures an opportunity to and timely correction of deficiencies. Admission of new patients with complex care needs does not occur. Facility staff can focus on meeting the care needs of the patients remaining in the nursing home.
- Speeds up the process of correction without compromising quality. The longer the stop placement is in effect, the greater the provider's financial burdens. The stop placement should not be removed until the survey agency confirms correction has occurred and systems are in place to assure lasting correction.

Consideration must be given to adding this very effective intermediate sanction to the proposed termination procedure.

The development of SOM sections, which address the issues of intermediate sanctions, termination procedures and guidelines for Medicare and Medicaid, requires a joint work effort on the part of federal and state officials. Such SOM sections must be legally sound and have as their primary consideration, the well being and protection of the patient.

Procedures for adverse actions which detail roles, responsibilities, authorities, and timeframes for action have been developed by the state of Washington in coordination with the Region X Regional Office. These procedures have been proven to be effective, efficient, legally sound, beneficial to the interests of the program and, most importantly, in the best interests of the patient. Representatives of the state of Washington would be willing to meet with HCFA Central office as part of a work group to draft effective SOM procedures that will be acceptable to, and usable by all states and regional offices. To reiterate our September 27, 1984 position, we stand ready to meet with federal officials at any place and at any time to assist in the resolution of problems and the development of sound, uniform procedures.

TERMINOLOGY

The termination procedures include a variety of new, undefined terms which are not supported in federal regulation. Because these terms have no basis in regulation, and are not defined, they create serious problems.

These undefined terms will lead to:

- Differences in interpretation, misinterpretation, misunderstanding and lack of uniformity of application among the state and federal offices,
- Serious legal stumbling blocks in that administrative law judges, hearing officers, and the courts will have to be convinced by us of the meanings of the terms, and
- Forcing the SA to rely on subjective terms rather than objective facts.

Examples of some of the terms include "immediate threat," "serious threat," "services of an adequate level or quality," "potential hazard," "unsolicited plans for correction," "early prospect of compliance," "credible allegation of compliance," "short form determination," "lock out," "credible evidence," and "reasonable assurance." Section 3725(B)(2), at the bottom of page 3-188, states a decision for a condition to be not met be based on a "subjective observation?" This seems to be a contradictory term.

CONFORMANCE WITH REGULATIONS

The proposed termination procedures create legal problems. A review by a Washington State Assistant Attorney General produced the following comments and questions regarding vague, often contradictory language:

- Page 3-179, 3720 Initial Denials B. Vacated Actions which are not Denials.

  It is unclear when you proceed with a denial instead of a vacated action. The provider must still receive due process.

- Page 3-182 F. Termination Action Based on On Site Federal Survey. "Survey findings and factual development are the responsibility of the RO, although the SA may be asked to assist in documenting or developing aspects of the termination." The assistance with documentation or developing aspects of the termination requires further clarification.

> This would result in an additional workload for the state agency. This raises the question of whether or not federal funding would be available for the increased costs.

The entire termination procedures must be reviewed to assure CFR language is being followed. The standards or regulations are being modified by paraphrasing,which creates potential legal problems. Some examples are:

> Page 3-189, 3726 A.2. "The facility...and the deficiencies seriously limit the provider's/supplier's capacity..."
>
> Page 3-191, 3727 A.3. Exception: The CFR states "furnish adequate care or threaten the health and safety," not adversely affect the health and safety.
>
> Section 3724 states "do not use the HCFA-2567 to convey the statement of deficiencies to the providers ..." This is contrary to federal regulations, which require the use of official Office of Management and Budget (OMB) approved forms cited at 42CFR 431.60(f)(1) and 42CFR.30(4).

Many parts of the procedure clearly indicate that the provider is not to be allowed to submit a Plan of Correction if termination is being pursued. In the state of Washington, a decertification case was lost at the State Court of Appeals level, due to this very issue. The Court ruled that the state erred in not obtaining a Plan of Correction and giving the provider the opportunity to achieve correction and compliance.

While the Code of Federal Regulations does not specifically require a Plan of Correction in cases where there is an unmet condition, it is not prohibitive on the issue either. Most state administrative procedures acts and due process requirements will allow the provider to submit a Plan of Correction or other statement of response to a cited deficiency. We cannot take away this right to respond even though the Plan of Correction may not be acceptable for recertification purposes.

Page 3-181, First paragraph following II. Statement: "However, in the course of a survey, a surveyor may encounter information which may be indicative of program abuse or failure to meet other program requirements..." It needs to be understood by the federal and state government that there is no penalty associated with the surveyor not being aware of program abuse or failure to meet other program requirements and, therefore, not reporting as noted.

The termination procedures are sufficiently restrictive to remove the decision process out of the realm of surveyor judgment. As currently proposed, the procedures are self-serving and mechanical rather than allowing experienced professional judgment to act in a manner which is in the best interest of the patients. It is axiomatic that decisions should be made at the lowest possible level.

Surveyors are required to initiate sustainable terminations when conditions at facilities call for them. Inclusion of voluminous steps, information and documentation by the State Agency (SA) simply creates an array of opportunities for a provider to attack a termination procedure.

Page 3-139, 3726 B. "The evidence and reasoning must include a summary of the basis for seclection of the category. Include the specific reasons for the ... failure to meet ... the statutory ments." Surveyor judgment is correctly the basis for selection of the category. It would be the responsibility of the provider to identify the specific reasons for their failure to meet the statutory requirements.

TIME LIMITED AGREEMENTS AND AUTOMATIC CANCELLATION

The reliance on Time Limited Agreements and Automatic Cancellation Clauses causes a tremendous drain on scarce survey resources with no benefit. A Time Limited Agreement is an agreement that has a specific ending date. If no action is taken to continue or extend the agreement, it ends on that date. In order to continue the agreement, the survey agency must complete a full survey of the provider no more than 120 days, but no less than 60 days, prior to the certification ending date. This means that the provider, who knows what the ending date is, knows when the survey team is coming within a 60-day "window" and is prepared for the survey. The survey team may be surveying under "artificial" situations. In addition, this is in violation of federal policy and Washington State law, which prohibit advance notice of a survey.

The primary problem with Time Limited Agreements is the loss of flexibility of the survey agency. Washington State currently operates with open-ended certification periods, which means that the certification can continue until there is an action to terminate it. The contract that the state enters into with the provider contains a clause that either party can terminate with 30 days written notice; the ultimate effect is that we do have a time limitation on the agreement. Under the open-ended contract, the state is free to set a given provider's survey frequency based upon degree of compliance achieved, compliance history, history of complaints, Inspection of Care findings, stability of key staff, and history of adequacy of corrective action. In other words, the state has the flexibility to be truly responsive to the situation. The "good" providers do not need to be surveyed as frequently as the "marginal" providers and, under Washington's system, they are not.

Each provider receives at least an annual survey, but when it occurs and how often is based on compliance. The providers with problems are the ones that need close, frequent monitoring. Under the open-ended contract, the state can utilize its survey resources to do this close. frequent monitoring to the ultimate end that the patients' health and safety are protected. If we go back to Time Limited Agreements, each provider is seen on a pre-determined schedule regardless of how well or how poorly they comply with the regulations. The provider knows approximately when to expect the survey. Limited surveyor resources are depleted as there is no flexibility allowed in the survey schedule. The patients in the marginal homes are not adequately protected. This a costly, inefficient, and ineffective system.

Using an open-ended contract, the only action needed is termination. It can be used at any time the facility is found to be in noncompliance. It is not tied to any time frame during the periods of the agreement, nor is it tied to an automatic cancellation clause, both of which can be readily predicted by the provider.

Any survey, even those generated by complaints, can be used to initiate a termination action when the provider is operating under an open-ended contract.

Serious complaints found to be valid can be used to generate a full survey and termination if indicated. In this manner those providers which have the poorest performance history also have the shortest survey cycles and, thereby, receive the most attention, until such time as their record reveals that they can provide adequate care with a longer survey cycle.

The same level of preparation; i.e., documentation/justification, is necessary for all three types of action: Termination, Non-renewal and Cancellation, so nothing is gained by using non-renewal or cancellation procedures. Conversely, use of cancellation and non-renewal procedures adds considerably to the confusion and volume of these procedures, particularly when it serves only to duplicate what we already use in the termination procedures.

Page 3-181 D. P.L. 97-35 permits open-ended contracts except that the federal government has the leeway to administer the program. This is a policy decision which HCFA may make but there also is no prohibition in the regulations (42 CFR 489.15-16 and 42 CFR 442.15-16) of allowing open-ended agreements. As a practical consideration the most important issue is the final result achieved without added paper work and increased costs to both the state and federal governments.

The instructions, detailing the process for rescinding the cancellation clause on page 3-193 are contradictory. Section 3728(A)(3) directs us to "state in the remarks section that the cancellation clause has been rescinded," while Section 3728(B)(3) directs us to "reflect in item 10(d) that the cancellation clause has been rescinded." Why the difference, and what legal implications does it raise?

On the other hand, page 3-194 Section 3728B states "Whenever a cancellation clause is permitted to operate, i.e., no action is taken to revoke it, process a HCFA-1539 to terminate the facility from participation" (emphasis added). This sentence implies that an action is required to stop the cancellation. Which is correct? Is it assumed that if the SA is unable to complete the revisit in a timely manner that the provider wculd automatically be terminated?

The automatic cancellation clause serves no purpose and has no real effect. Washington State formerly wrote agreements with automatic cancellation clauses but found that implimentation of this provision is still a legal termination action and due process legal requirements apply. There is nothing "automatic" about the concept. It is required that we prove patient health and safety jeopardy before any termination action can be taken. The automatic cancellation clause concept is well-intentioned, but it does not work in practice and should be discarded.

IMMEDIATE THREAT

Section 3724, page 3-184 lists some examples of situations that constitute an "immediate or serious threat to patient health or safety." This section goes on to explain the timeline for action in such cases and allows 40 days for the termination action to occur.

We agree that some of the examples shown constitute an immediate threat. In those cases, the state of Washington currently uses the term "immediate" to mean there is a problem of such severity and/or magnitude that it must be resolved immediately, or requires immediate relocation of patients. In such cases, we cannot allow 40 days to pass. Once the problem is identified, we are legally bound to ensure action sufficient to protect the health and safety of patients. To identify the problem as an "immediate threat" and then to walk away and do nothing further makes the state culpable and liable should further harm occur.

Some of the examples obviously do not meet this narrow definition of "immediate." As always, the only person in position to judge the severity and immediacy of threat is the professional surveyor on site. That is the person we rely upon to tell us what is wrong and how serious it is. The SA cannot rely on a list of examples or "critical" regulations to make those professional judgment decisions.

Wesley Brock, M.D., Assistant Medical Director, Division of Medical Assistance, supports this analysis. His and the Assistant Attorney General's comments are as follows:

> None of these examples are serious by themselves - How many such problems were there? What was the sample size? What are the documented patient outcome problems?
>
> Example No. 1 identifies fire hazzards as emergency situations. What are emergency situations? This is too broad. A fire hazard could be serious depending upon ease of correction. Having the main fire sprinkler valve shut off is very serious and yet it can conceivably be corrected in about two minutes by turning the valve back on. Is this serious enough to warrant a condition not met and take negative action?
>
> No. 2 cites failure to perform bacterial counts. Nationally recognized control organizations involved in infection control such as Center for Disease Control, Association for Practitioners in Infection Control, National Sanitation Foundation, International Association of Milk, Food, and Environmental Sanitarians, National Environmental Health Association, American Society of Clinical Pathology, etc. have uniformly discounted the efficacy of routine plate counts as long as 15 years ago.
>
> No. 3 addresses widespread rodent infestation. "Widespread" is too general a term. It would be necessary to prove disease associated with insect or rodent infestation.
>
> No. 4 reflects more concern with the review of the homes and providers than in patient care.
>
> No. 5 states "Widespread patient abuse or poor patient care ..." "Widespread" use is too general. Habitual might be a better word. Abuse; is this neglect or patient abuse, or staff to patient abuse? If not neglect, the issues should be separated.
>
> No. 6 agrees with the seriousness of failure to adequately isolate patient with communicable disease.
>
> In addition, it seems that a very major problem was totally ignored, namely, the quality of medical care by the physician including problems such as lack of physician coordination and failure in diagnostic and therapeutic delivery.

It is also noted that the criteria seem to be rigid and allow for little or no professional judgment of quality of care as opposed to a laundry list of survey matters. Failures in the function and coordination of the professional staff can be a much more immediate and serious threat to the integrity of the fragile, brittle, often multi-system diseased resident than many of the items listed.

REASONABLE ASSURANCE

In Section 3070, the examples used to describe how to apply the concept of "reasonable assurance" after an involuntary termination allow for a wide range of time periods of 30 days up to one year before readmission to the Medicare or Medicaid program. The concept could create problems for the state agency and negatively impact the welfare of the long-term care patient.

In Washington State, the average occupancy rate of nursing homes is about 97 percent. Relocation of nursing home patients because of involuntary termination is a tremendous problem. With this concept, patients would have to be relocated long distances away from family or significant others. With a high occupancy rate, a 30-day period for relocation is insufficient. Often the provider is accepted back into the program, making the relocation efforts moot.

The application of a reasonable assurance concept calls for careful, professional and prudent judgment. Intermedicate sanctions are more often advisable and preferred actions. With those providers who demonstrate repeated violations, other sanctions may need to be considered such as civil fines, stop placement of patient admission, stop payment or not allowing the provider to re-enter the program.

In those cases where the reasonable assurance concept should be legitimately used, the period of the assurance should be at least one year in order that there be a true penalty assessed and provide a strong incentive for the provider to remain in full compliance.

If a provider goes into termination and then sells the operation to a new provider, certain actions should occur.

- The termination action against the provider, whose actions or inactions caused the termination, should proceed to completion.
- If the negligent provider wishes to re-enter the program by purchasing another facility, that provider should then be subject to a one-year period of demonstrating compliance with laws rules, and regulations before being re-admitted to the either Medicare or Medicaid program(s).
- If the operation is sold to another provider who has a "good" track record, that "good" provider should be allowed to obtain certification and an agreement. There should even be an incentive for "good" providers to take over operations in trouble and achieve correction. There should be an effort to promote the expansion of good operators and attempt to limit the expansion of the "bad actors."

The most important principle would be to punish the operator responsible for the adverse action; not to punish the patients who happen to be living in the facility.

TIME FRAMES

Washington State believes some of the forms and procedural time tables used are confusing for the following reasons:

- Forty (40) days should not be allowed for correction when an "immediate threat" exists. As previously mentioned, in Washington, "immediate threat" means there is a high probability that unless action is taken within 24 hours to remove the patient(s), the threat of death will occur.

  An "immediate threat," therefore, usually requires a summary suspension or license revocation.

- The SOM should provide a maximum number of days for completion of the termination. Beyond that, the procedures should allow the state the flexibility to develop a time table schedule and procedures which work for their state. For example, the 100-day procedures are confusing and not cost effective. They call for two post surveys -- one at 30 and another at 60 days. There is uncertainty as to whether these procedures are to be used for Medicare or Medicaid termination or both. Washington has developed procedures for termination which are cost effective and which work for the state. At the same time, they follow the CFR, meet the intent of the law and protect the long-term care patients in the state.

ORGANIZATION

The termination procedures are written in a confusing, unorganized manner. The procedures for Medicare providers and the procedures for Medicaid providers are intermingled to the extent that the reader cannot tell which applies in a given situation. The entire set of procedures must be rewritten in clear, concise terms and must clearly delineate and differentiate the Medicare process from the Medicaid process and conform to existing state plans.

The procedures violate the existing State Plan for the implementation of Title XIX Medicaid programs. Title XIX of the Social Security Act mandates states to develop State Plans, which are accepted by the Secretary and administered and operated by the individual states. 42 CFR 430.0(A) identifies that the Secretary's authority to prescribe State Plan requirements must be on statutory requirements. The requirements, as prescribed by the Secretary, are to be reflected in the approved State Plan.

The consistent referencing of Title XVIII, which is solely a federally administered program, with Title XIX, which is by law administered and operated by the states, is an infringement of the federal government into the state domain.

A few examples from the revised procedures are:

- Section 3721 E. This paragraph identifies that each state has developed procedures for termination for Title XIX providers, but then proceeds to direct specific procedures.

- Section 3721 F. states "The S.A., and the State Medicaid Agency... are notified of the action being taken." This is in reference to surveys conducted by the Regional Office. This action for Title XIX providers bypasses and unlawfully supersedes the state's authority and responsiblity as mandated by regulation and identified in the current State Plan. In these instances the appropriate action would be for the Regional Office to notify the S.A. of the findings of threat to health and safety and then jointly proceed according to each agency's procedures and responsibilities.

To summarize, we have conducted a thorough analysis of these draft termination procedures and have also involved the Assistant Medical Director of the Division of Medical Assistance and our State's Assistant Attorney General. While this draft is slightly better than the original, we still feel that there are many serious problems with these proposed termination procedures.

We would welcome the opportunity to sit down together to develop good, legally defensible, acceptable procedures and guidelines to ensure uniformity of interpretation and action across the nation. The outcome of such a work session would be most beneficial to the Medicare/Medicaid program, the federal and state governments and, most importantly, the patients whom we serve.

DEPARTMENT OF HEALTH & HUMAN SERVICES REGION III

Memorandum

Date November 9, 1984

From Regional Inspector General for Audit

Subject Proposed TOP Research Project - Swing-Beds

To Assistant Inspector General for Audit

The swing-bed provisions of the Omnibus Reconciliation Act of 1980 allowed certain small, rural hospitals (less than 50 beds) to use their inpatient facilities to furnish SNF and ICF services to Medicare and Medicaid beneficiaries while being reimbursed at rates appropriate for those services. These provisions were intended to encourage the most effective and efficient use of inpatient hospital beds in areas with declining occupancy rates (less than 80%) and critical shortages of nursing home beds.

HCFA anticipated approximately 1,350 hospitals nationwide being affected by the swing-bed provisions. However, the majority of the targeted hospitals apparently determined the swing-bed provisions too restrictive and inflexible to be cost beneficial because only 309 hospitals in 31 states have designated swing-beds. Region III, owning one of the heaviest concentrations of hospitals targeted for swing-bed certification in the country, has no swing-beds, and, the region's nursing home occupancy rates remain high while Medicare and Medicaid patients - wait-listed for nursing home placement - occupy acute care hospital beds.

Criteria Used to Develop Swing-Bed Provisions Is Now Applicable to All Hospitals

In adopting the swing-bed provisions, the House Commerce Committee was aware that a number of large hospitals, in areas with a scarcity of nursing home beds, could use and were using unoccupied acute care beds to provide a less intensive level of care. To determine the feasibility of adopting the swing-bed concept in larger hospitals, HCFA was required to review the situation and report their results to Congress by December 1983. This review was not performed timely and currently, no report is expected until 1986. In the meantime, however, hospital bed occupancy rates have steadily fallen.

For example, the average occupancy rates for hospitals in the Philadelphia area has fallen from 84 percent in 1981 to about 68 percent in 1984. These percentages relate to between 1,000 and 2,500 unnecessary/unoccupied hospital beds in the Philadelphia area and, as many as 25,000 such beds throughout Pennsylvania. Maryland, Michigan, Wisconsin, New York and Ohio are experiencing similar problems. In Maryland, there were between 1,600 and 2,300 excess hospital beds during 1983. As hospital use continues to decline in Maryland, excess beds are expected to double by 1988. In Ohio, there is a movement to eliminate 2,300 unnecessary hospital beds that Blue Cross no longer wants to pay for. Not only are the beds not being used, they are costing millions of dollars a year to maintain. Blue Cross has estimated that maintaining the 2,300 unnecessary hospital beds costs approximately $130 million or about $56,520 per bed, annually. Using the Blue Cross estimates in the Pennsylvania situation, the cost of maintaining unnecessary beds ranges from about $424 million to $1.4 billion annually. Nationally, the cost of maintaining unnecessary hospital beds could be astronomical.

Nursing Home Beds Are Scarce

Declining patient populations in hospitals has triggered the opposite reaction in the nursing home environment, namely, steady increases in occupancy rates resulting in nursing home bed shortages. These shortages in nursing home beds are not limited to rural areas but have spread to large metropolitan areas nationwide. As early as 1980, Professional Standard Review Organizations, among others, found thousands of Medicare and Medicaid patients being kept in costly acute care hospitals instead of being placed in nursing homes mainly because of bed shortages. Medicare and Medicaid patients can expect the nursing home bed shortage situation to worsen with the onset of prospective payment systems. Medicare's prospective payment plan is expected to get patients out of hospitals as quickly as possible. In most cases, quick discharges will mean that patients still require additional care - usually in nursing homes - and hospitals will be competing with each other to place their patients in the diminishing nursing home bed market. It is safe to say that many Medicare and Medicaid patients will not be accommodated in existing nursing home beds. In such cases, hospitals will be forced to continue providing care to patients at a SNF or ICF level of care or put patients out in the street.

Pennsylvania Experience

During recent visits to rehabilitation and psychiatric hospitals in Pennsylvania, we found that both facilities were experiencing difficulty in placing Medicare patients ready for discharge in nursing home beds. At the 90 bed rehabablilitation hospital, we found that patients were remaining an average of 4 additional days after the need for nursing home care had been made because nursing home beds were not readily available. Medicare reimbursed the facility at its full per diem rate and for the reasonable cost of ancillary services - about $250 per patient, per additional day. This reimbursement was significantly higher than the SNF reimbursement would have been if a nursing home bed were available.

At the psychiatric hospital, the administrator told us about the difficulties experienced in trying to place discharged patients - the majority of which had been rehabilitated but still in need of nursing home care. The psychiatric hospital was also incurring additional days for patient care and was being reimbursed, in full, for the services provided.

Research Is Continuing

In our opinion, the time is right for the expansion of the swing-bed concept to all hospitals regardless of size or geographic location. The simplification and expansion of the swing-bed provisions of the Omnibus Reconciliation Act would ensure that hospitalized Medicare and Medicaid patients continue receiving necessary care but, at significantly lower SNF or ICF reimbursement rates. Numerous advantages would be realized by both hospitals and Medicare/Medicaid patients, namely, hospital occupancy rates would stabilize, open competition for patients would be created, premature discharges would be curtailed, and cost savings would be realized through reduced Medicare and Medicaid reimbursement.

Research is continuing in this area. We plan to hold discussions with hospital and nursing home administrators, as well as HCFA officials to obtain their views. Once these steps have been completed, we will prepare a TOP report. I will be happy to discuss this proposal with you further should you have any questions or comments.

G. A. Rafalko

cc:
Director, HCFA Audit Division
Deputy Director for Audit Operations
Audit Coordination Division

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United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, D.C. 20510

November 13, 1984

Mr. Charles Baker
Under Secretary for Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Mr. Baker:

I would like to thank you and Ms. Knight for coming to my office to discuss solutions to the problem of nursing home discrimination identified in the Committee's October 1st hearing. I appreciate your frankness in discussing what has become a troublesome issue for your Department.

Your commitment on behalf of the Secretary that DHHS will, by the end of this year, publish a final rule implementing the Alternative to Decertification authority is a welcome resolution to this problem. Please let us know if OMB objections or other unforeseen events will prevent this from happening.

I also appreciate your fast action in convening a formal working group of representatives from key DHHS agencies with authority to respond to allegations of discriminatory practices. The Inspector General should properly remain outside of such a group, however, to observe and report to the Congress on its effectiveness in bringing about enforcement of beneficiaries' rights.

Your agreement to communicate the law to key State and Federal agencies is very important. Most have very little understanding of the protections available to patients, and what their position should be on these issues. I have enclosed the memoranda issued earlier by HCFA Central and Regional offices, to assist you in preparing the new materials for dissemination (please see Items 1 and 2, attached). Before they are reissued, however, I would like to direct you to what I consider to be serious shortcomings in these memos as they were originally drafted.

The memos quote portions of Section 1909(d)(2), which states in pertinent part:

> "Whoever knowingly and willfully charges, solicits, accepts, or receives...any gift, money, donation, or other consideration...as a precondition of admitting

a patient to a hospital, skilled nursing facility, or intermediate care facility, or as a requirement for the patient's continued stay in such a facility...shall be guilty of a felony..."(emphasis supplied).

Problems arise, first, because the HCFA Regional memos sent to the States omit the key phrase "or other consideration", underlined in the passage above. This omission means that serious problems are allowed to continue such as requirements that a "responsible party" sign the admissions agreement of a Medicaid eligible patient as a precondition of admission. Such requirements, common in many States, constitute "other consideration" within the meaning of 1909(d). I believe it will be helpful for DHHS to explain in upcoming memoranda how this phrase limits the circumstances in which a "responsible party" requirement is legal (partially discussed in Item 2 at Question 2.)

Second, the memos focus solely on nursing home admissions policy, by omitting reference to the phrase concerning "the patient's continued stay in the facility". The omission is significant. As the Committee's hearing revealed, most private pay patients spend down within a year or two of admission, and those residents who have signed a private pay contract are often subjected to threats of eviction at the time they become eligible for Medicaid. If this key phrase is omitted, States will remain unaware of their duty to enforce the Patients' Rights Provisions limiting the circumstances when a resident may be involuntarily transferred, and which require the provider to explain those rights to each patient.

Therefore, the original language in HCFA's central office memorandum dated June 14, 1983 (Item 1, Question 1) should be made available to key agencies concerned with discrimination.

Third, while the Civil Rights Act is mentioned in the Regional office memos, they omit any reference to Section 504 of the Rehabilitation Act of 1973, as Amended. This important civil rights statute establishes the right of handicapped persons to receive from federally supported providers services equal in quality and effectiveness to those provided to other patients.

DHHS should explain that Congress intended this law to be applied to the problems "heavy care patients" have in gaining admission to certified nursing homes. For example, 1974 amendments to section 504 were accompanied by conference report language explicitly defining "[e]xamples of handicapped individuals who may suffer discrimination in the receipt of federally assisted services but who may have been unintentionally excluded from the protection of Section 504...as... handicapped persons who may be denied admission to federally assisted nursing homes on the basis of their handicap..." Since that time, we are aware of only one case which has been handled appropriately under this statute by the Office of Civil Rights (please see Item 3, "OCR Opinion...," attached).

My concern is that the prevalence of this problem as evidenced in numerous studies of "hospital backup," is much greater than the volume of complaints received and investigated by OCR. Most beneficiaries and many State officials continue to be unaware of the implications of Section 504 for nursing home admissions practices. I would therefore request that provider responsibilities under the Civil Rights Act and Section 504 of the Rehabilitation Act will be fully described to all appropriate agencies.

We agreed that the new DHHS communications would be sent to the State Ombudsman programs and the State survey and certification agencies. I would also encourage you to send these to the Administration on Aging and the regional and local Ombudsman programs it oversees, HCFA's central and regional offices, State Medicaid agencies, State Attorneys General, Medicaid Fraud Control Units, and State Departments of Consumer Protection. Unless each of these entities is fully informed, we cannot expect enforcement to be adequate. I suggest that you also consider a training program for AoA's Ombudsman programs, to ensure that DHHS policy is fully implemented at the State and local levels.

Once again, thank you for your personal attention to the matters raised by the Committee's investigation. I am confident we can resolve these problems to the benefit of elderly and disabled Medicaid beneficiaries.

Warm regards,

John Heinz

JOHN HEINZ
Chairman

Enclosures

JH:dsm

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

FQA-83

Memorandum

Item 1: HCFA Central Office
Memoranda

Date JUN 14 1983

From Director
Bureau of Eligibility, Reimbursement,
and Coverage

Subject Medicaid Admissions to New Jersey Nursing Homes—(Your Memorandum Dated May 25, 1982)—POLICY INFORMATION FOR ALL REGIONS

To Regional Administrator
Region II, New York
Attn: Policy and Technical Assistance Branch
Division of Program Operations

In your memorandum you brought up the problem that some New Jersey nursing homes have been refusing to accept Medicaid or potential Medicaid eligible patients unless the patient or their families pay at the private pay level for a specific time period under contracts between the nursing home and the patients or their families.

As we pointed out in our interim memorandum of July 22, 1982, there is no Federal prohibition against private individuals who are not Medicaid recipients entering into such contracts with nursing homes. We also indicated we would consult with our Office of the General Counsel regarding the application of section 1909(d) of the Social Security Act to these contracts. The Office of the General Counsel has advised us that section 1909(d) is a criminal statute and that no one within the Department can give a definitive interpretation regarding the scope and applicability of a criminal statute since those matters are within the province of the Department of Justice, individual United States Attorneys, grand juries, and ultimately the courts. Where information is available suggesting a potential violation of section 1909(d), such cases should be referred to the Office of the Inspector General for investigation and appropriate action. (e.g., referral to the appropriate United States Attorney's Office). The advice below is thus provided on an informal basis.

1. If a patient, who has signed singly such an agreement with a nursing home, becomes Medicaid eligible prior to the expiration date of the agreement, can the contract be voided legally and the costs of his stay in the facility than be reimbursed by the State Medicaid agency?

Section 1909(d)(2)(B) prohibits the charging or soliciting of "money—or other consideration—as a requirement for the patient's continued stay in (the) facility." Therefore, in the case of a private pay patient who becomes Medicaid eligible, and Medicaid assumes the cost of care in the facility, a contractual provision requiring the continued payment of private pay rates seems contrary to section 1909(d)(2)(B). Although the statute may not have applied to the agreement when it was executed (because the patient was not a Medicaid beneficiary), payments under the agreement in excess of the Medicaid rate cannot be charged once the individual's care is covered by Medicaid.

2. If a contract is signed jointly by patient and relative and the patient is determined to be Medicaid eligible prior to its expiration can that contract be voided as well and reimbursement be picked up by Medicaid?

The prohibition in section 1909(d)(2)(B) applies not only to the charging or soliciting of money from the patient but from anyone, including relatives of the patient. Therefore the continued payment of private pay rates seems contrary to section 1909(d)(2)(B) for the reasons noted in response to question 1.

3. Can a contract between the patient's relative and the facility be declared invalid if, prior to its termination, the patient is determined to be eligible, and can reimbursement then be picked up by Medicaid?

The answer given for question number 2 would apply.

4. Some facilities require "private pay" contracts to be signed by prospective patients who are already Medicaid eligible prior to admission. Are such contracts valid?

Section 1909(d)(2)(A) prohibits the charging or soliciting of "money . . . or other consideration . . . as a precondition of admitting a patient to a skilled nursing facility, or intermediate care facility,". Therefore the requiring of such a contract seems contrary to the statute.

If you have any questions please contact Dick Born FTS-8-934-6443.

Larry A. Oday

HCFA PROGRAM ISSUANCE
Transmittal Notice
REGION IV

DATE: November 2, 1983 PROGRAM IDENTIFIER: MCD-29-83 (PO)

Item 2: HCFA Regional Office
Memoranda

TO: All Title XIX State Medicaid Agencies

SUBJECT: Freedom of Choice Issues Involving Long-Term Care Providers

In response to questions from several States, we asked our Central Office for guidance on several issues which involve the freedom of nursing homes to deny admission to Medicaid recipients. The specific questions and responses are as follows:

Question 1:

Can a nursing home that has a vacancy deny admission of a Medicaid patient in need of nursing home care?

Response:

Yes. Admission of a Medicaid patient in need of nursing home care can be denied if the denial is not in violation of the Civil Rights Act. According to Section 1902(a)(23) of the Social Security Act, the "freedom of choice" provision, a State plan is required to provide "that any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required... who undertakes to provide him such services ..." (emphasis added).

In the situations raised by Question 1 (e.g., if the recipient's needs cannot be met by the institution) the recipient has no statutory right of admission under the freedom of choice provision of the Act. The Office of the General Counsel (OGC) advised that two parts of the statute may reasonably be interpreted to reach this conclusion. First, the provider has not "undertaken to provide him such services," i.e., is not willing to do so. Second, assuming that the nursing home cannot meet the medical needs of the recipient, the nursing home would not be "qualified to perform" the services needed and there would consequently be no right of admission.

There is no other provision of the statute or regulations that grants such a right of admission. Therefore, we believe that the nursing home's action would be legal.

Question 2:

Can a nursing home deny admission to Medicaid patients who have no responsible party to pay for services not covered by Medicaid, while admitting Medicaid patients that do have such responsible parties?

Response:

We believe that the answer is affirmative because Section 1902(a)(23) of the Act does not establish a right of admission for the first category of recipients where the provider has not "undertaken to provide (the) services." Once again there is no other Medicaid provision which would prohibit such discrimination.

However, States may legislate in the area of nursing homes' ability to deny access to Medicaid recipients. If by State law a nursing home is prohibited from denying access in general or in the particular situations discussed here, then the action would be illegal under State law and, therefore, the provider would not be "qualified" to participate in the Medicaid program because State provider requirements are not met. For example, the State would require the nursing home in (1) to obtain the needed services, or in (2) prohibit discrimination against recipients without a responsible party.

Question 3:

Can a nursing home charge or solicit money from a patient or the patient's relatives as a condition of admission?

Response: [illegible]

While nothing in the Medicaid statute or regulations compels a provider of institutional services to admit a Medicaid recipient, section 1909(d)(2)(A) prohibits the charging of a fee as a precondition to admitting a patient whose care is paid for by Medicaid. Thus, we believe that there may be a potential violation of the statute when a prospective patient who receives Medicaid benefits is eligible to have Medicaid pay for care in the nursing home is required to contract with the facilities to pay an amount in excess of the Medicaid rate as a condition of admission. This may be viewed as the charging or soliciting of "money ... as a precondition of admitting a person" to the facility when the cost of that person's care is to be paid for by Medicaid.

It should be noted that OGC has advised that Section 1909(d) is a criminal statute and that no one within this Department can give a definitive interpretation regarding the scope and applicability of a criminal statute since those matters are within the province of the Department of Justice, individual United States attorneys, grand juries, and ultimately the courts. If it appears that a potential section 1909(d) violation is involved, the case should be referred to the Office of the Inspector General.

If there are any further questions regarding these issues, please contact Cathy Kasriel at (404) 221-2407.

George R. Holland
Regional Administrator
Health Care Financing Administration

Item 3: OCR Opinion in Case
of Crestwood (SNF)

JAN 14 1981

TO : Mr. Floyd Pierce, Regional Director
Office for Civil Rights, Region IX

FROM : Ana Maria Martel, Deputy Director
Office of Compliance and Enforcement

Ana Maria Martel

SUBJECT : Crestwood Manor Compliance Review
(09-77-3440)

This is in response to your request for written clarification on whether and how persons with the following medical conditions and/or requirements are considered "qualified handicapped persons" as defined by 45 CFR 84.3 (j) and (k)(4):

- Class IV decubitus ulcers (bed sores)
- Colostomy
- Ileostomy
- Respiratory therapy
- In-dwelling catheter

You indicate that Crestwood Manor has challenged OCR's finding that the facility's policy of refusing admission to such persons is in violation of Section 504. Specifically, Crestwood officials have stated that they are unwilling to negotiate on this issue because they reject OCR's conclusion that such persons are protected by the Section 504 statute.

Conclusion

Based on extensive discussions my office has had with the Office of Program Development and the Office of General Counsel, we can now provide the guidance you requested. Section 504 provides that:

> No qualified handicapped person shall, on the basis of handicap, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity which receives or benefits from Federal financial assistance.

We have determined that persons with the medical conditions and/or requirements listed above are "handicapped" to the extent that these conditions are serious enough to substantially limit a major life activity. When such individuals are certified by a physician as needing SNF care, they are "qualified" to receive SNF services from a facility receiving Federal financial assistance. For purposes of clarity, we will discuss separately: (a) how persons with such conditions may be considered to be handicapped, and (b) how persons with these or other conditions are considered "qualified," for purposes of admission to skilled nursing facilities.

DEPARTMENT OF HEALTH & HUMAN SERVICES **REGION III**

Memorandum

Date NOV 13 1984

From Regional Inspector General for Audit

Subject Planned National Review on Survey and Certification Activities at Skilled and Intermediate Nursing Facilities

To Regional Inspector General for Audit
Region X

The Inspector General has been requested by the U.S. Senate Special Committee on Aging to conduct a nationwide review of survey and certification activities at skilled and intermediate nursing facilities. This request was based on allegations received by the Committee on specific instances of poor physical conditions at nursing homes and inadequate patient care. Follow-up work by the Committee indicates that both Federal and State controls over nursing homes need strengthening. Region III, Office of Audit was assigned the responsibility for the project because the specific nursing home in question was in Pennsylvania.

As part of our survey, we have made a preliminary analysis of nursing home licensing and inspection data available on HCFA's Medicare/Medicaid Automated Computer System (MMACS). This information combined with other information gathered during our survey has lead us to request your participation in the national project.

Initially we have concentrated on three specific areas of concern:

1. Facilities that did not meet important conditions and standards as reported on MMACS. We selected 7 conditions and 25 standards we felt were most related to patient care and designed computer programs that identified facilities that did not meet one or more of our predetermined criteria relative to the conditions and standards.

2. Facilities that were not surveyed within the last 18 months. Federal law does not require annual surveys but Federal regulations were not changed. These regulations still require annual surveys. We identified many homes that, according to MMACS, were not surveyed within the last 18 months. We also found, however, that in Region III, HCFA did not always input data on nursing homes in the termination process. Therefore, the nursing homes we identified were either not surveyed or could be experiencing serious health and safety problems.

3. Facilities that were not fully surveyed. Federal regulations require that all conditions of participations be reviewed during the facility's annual survey. Our initial MMACS applications indicated that several states are reviewing selected conditions of participation.

In Region X, we are interested in obtaining information on the last two points. Our analysis has indicated that 146 (12 percent) of the 1,243 facilities that were reported to have been last surveyed over 18 months ago are located in your Region. Also, our survey has indicated that the state of Washington is performing "partial" surveys. As a start of the national review we would like to address these two areas.

I am providing as an attachment to this memorandum a short list of questions that we would like answers to. However, before contacting HCFA and the various state agencies I would appreciate it if your staff members assigned meet with the audit supervisor on my staff who will provide additional details and background information.

If you have any questions or wish to discuss this matter further, please contact me, or have a member of your staff contact James Maiorano of this office.

G. A. Rafalko

Attachment

Preliminary Questionnaire

Facilities Not Surveyed in Last 18 Months

1. Can HCFA explain why these facilities appear on MMACS as not being surveyed in last eighteen months.
2. For a sample of facilities in each state determine if there is a pattern that could explain why they appeared on the list - is it an indication of a potentially deficient facility that is in the process of being removed from the Medicare and/or Medicaid program.
3. If there are "clerical problems" in updating the MMACS determine what is causing the problem. Could the problem be a sign that substandard homes could be allowed to continue in the program undetected.

Partial Surveys (Washington Only)

1. Determine why the state of Washington is performing only partial surveys.
2. Under what authority is Washington acting.
3. Is HCFA aware of this practice?
4. If the partial surveys are being done with knowledge and approval from HCFA what were they trying to accomplish.
5. What criteria was used to develop the strategy for selecting the specific condition that were included in the partial surveys. Were they consistent?
6. Has this process (partial surveys) been successful according to HCFA? According to Washington officials?
   a. Can cost savings be attributed to this action?
   b. Any changes in the quality of care or condition of facilities noted?

ATTACHMENT

DEPARTMENT OF HEALTH & HUMAN SERVICES REGION III

Memorandum

Date: NOV 13 1984

From: Regional Inspector General for Audit

Subject: Planned National Review on Survey and Certification Activities at Skilled and Intermediate Nursing Facilities

To: Regional Inspector General for Audit
Region V

The Inspector General has been requested by the U.S. Senate Special Committee on Aging to conduct a nationwide review of survey and certification activities at skilled and intermediate nursing facilities. This request was based on allegations received by the Committee on specific instances of poor physical conditions at nursing homes and inadequate patient care. Follow-up work by the Committee indicates that both Federal and State controls over nursing homes need strengthening. Region III, Office of Audit was assigned the responsibility for the project because the specific nursing home in question was in Pennsylvania.

As part of our survey, we have made a preliminary analysis of nursing home licensing and inspection data available on HCFA's Medicare/Medicaid Automated Computer System (MMACS). This information combined with other information gathered during our survey has lead us to request your participation in the national project.

Initially we have concentrated on three specific areas of concern:

1. Facilities that did not meet important conditions and standards as reported on MMACS. We selected 7 conditions and 25 standards we felt were most related to patient care and designed computer programs that identified facilities that did not meet one or more of our predetermined criteria relative to the conditions and standards.

✓ 2. Facilities that were not surveyed within the last 18 months. Federal law does not require annual surveys but Federal regulations were not changed. These regulations still require annual surveys. We identified many homes that, according to MMACS, were not surveyed within the last 18 months. We also found, however, that in Region III, HCFA did not always input data on nursing homes in the termination process. Therefore, the nursing homes we identified were either not surveyed or could be experiencing serious health and safety problems.

✓ 3. Facilities that were not fully surveyed. Federal regulations require that all conditions of participations be reviewed during the facility's annual survey. Our initial MMAC applications indicated that several states are reviewing selected conditions of participation.

In Region V, we are interested in obtaining information on the last two points. Our analysis has indicated that 503 (40 percent) of the 1,243 facilities that were reported to have been last surveyed over 18 months ago are located in your Region. Also, our survey has indicated that the state of Wisconsin is performing "partial" surveys. As a start of the national review we would like to address these two areas.

I am providing as an attachment to this memorandum a short list of questions that we would like answers to. However, before contacting HCFA and the various state agencies I would appreciate it if your staff members assigned meet with the audit supervisor on my staff who will provide additional details and background information.

If you have any questions or wish to discuss this matter further, please contact me, or have a member of your staff contact James Maiorano of this office.

G. A. Rafalko

Attachment

Preliminary Questionnaire

Facilities Not Surveyed in Last 18 Months

1. Can HCFA explain why these facilities appear on MMACS as not being surveyed in last eighteen months.
2. For a sample of facilities in each state determine if there is a pattern that could explain why they appeared on the list - is it an indication of a potentially deficient facility that is in the process of being removed from the Medicare and/or Medicaid program.
3. If there are "clerical problems" in updating the MMACS determine what is causing the problem. Could the problem be a sign that substandard homes could be allowed to continue in the program undetected.

Partial Surveys (Wisconsin Only)

1. Determine why the state of Wisconsin is performing only partial surveys.
2. Under what authority is Wisconsin acting.
3. Is HCFA aware of this practice?
4. If the partial surveys are being done with knowledge and approval from HCFA what were they trying to accomplish.
5. What criteria was used to develop the strategy for selecting the specific condition that were included in the partial surveys. Were they consistent?
6. Has this process (partial surveys) been successful according to HCFA? According to Wisconsin officials?
    a. Can cost savings be attributed to this action?
    b. Any changes in the quality of care or condition of facilities noted?

ATTACHMENT

DEPARTMENT OF HEALTH & HUMAN SERVICES **REGION III**

Memorandum

Date . NOV 15 1984

From Regional Inspector General for Audit

Subject Planned National Review on Survey and Certification Activities at Skilled and Intermediate Nursing Facilities

To Regional Inspector General for Audit
Region IV

The Inspector General has been requested by the U.S. Senate Special Committee on Aging to conduct a nationwide review of survey and certification activities at skilled and intermediate nursing facilities. This request was based on allegations received by the Committee on specific instances of poor physical conditions at nursing homes and inadequate patient care. Follow-up work by the Committee indicates that both Federal and State controls over nursing homes need strengthening. Region III, Office of Audit was assigned the responsibility for the project because the specific nursing home in question was in Pennsylvania.

As part of our survey, we have made a preliminary analysis of nursing home licensing and inspection data available on HCFA's Medicare/Medicaid Automated Computer System (MMACS). This information combined with other information gathered during our survey has lead us to request your participation in the national project.

Initially we have concentrated on three specific areas of concern:

1. Facilities that did not meet important conditions and standards as reported on MMACS. We selected 7 conditions and 25 standards we felt were most related to patient care and designed computer programs that identified facilities that did not meet one or more of our predetermined criteria relative to the conditions and standards.

2. Facilities that were not surveyed within the last 18 months. Federal law does not require annual surveys but Federal regulations were not changed. These regulations still require annual surveys. We identified many homes that, according to MMACS, were not surveyed within the last 18 months. We also found, however, that in Region III, HCFA did not always input data on nursing homes in the termination process. Therefore, the nursing homes we identified were either not surveyed or could be experiencing serious health and safety problems.

3. Facilities that were not fully surveyed. Federal regulations require that all conditions of participations be reviewed during the facility's annual survey. Our initial MMACS applications indicated that several states are reviewing selected conditions of participation.

In Region IV, we are interested in obtaining information on the first point. Our analysis has indicated that several states in your region had a relatively high number of facilities that did not meet important conditions and standards for a long period of time as reported on MMACS. Specifically, we are interested in the states of Georgia, Alabama, Mississippi, and Kentucky. Facilities in these states matched our parameters 152 times. As a start of our national review we would like to address this area.

I am providing as an attachment to this memorandum a short list of questions that we would like answers to. However, before contacting HCFA and the various state agencies I would appreciate it if your staff members assigned meet with the audit supervisor on my staff who will provide additional details and background information.

If you have any questions or wish to discuss this matter further, please contact me, or have a member of your staff contact James Maiorano of this office.

G. A. Rafalko

Attachment

Failure to Meet Specified Conditions/Standards Over a Period of Time

1. Determine latest status of each of the facilities identified.
2. Review files at HCFA to determine details on each facility (or a sample if need be). We should be looking for things such as:

   ... how long have the identified deficiencies existed.

   ... what actions have been taken, or are planned, to improve facility or remove it from participation (Both by HCFA and state).
3. Determine at the State AGency the status of each of these facilities. Has all information been forwarded to HCFA.
4. Would a site visit to facilities be warranted? Is there a need for outside consultants (medical or other) to get involved?

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES REGION III

Memorandum

Date NOV 15 1984

From Regional Inspector General for Audit

Subject Planned National Review on Survey and Certification Activities at Skilled and Intermediate Nursing Facilities

To Regional Inspector General for Audit
Region IX

The Inspector General has been requested by the U.S. Senate Special Committee on Aging to conduct a nationwide review of survey and certification activities at skilled and intermediate nursing facilities. This request was based on allegations received by the Committee on specific instances of poor physical conditions at nursing homes and inadequate patient care. Follow-up work by the Committee indicates that both Federal and State controls over nursing homes need strengthening. Region III, Office of Audit was assigned the responsibility for the project because the specific nursing home in question was in Pennsylvania.

As part of our survey, we have made a preliminary analysis of nursing home licensing and inspection data available on HCFA's Medicare/Medicaid Automated Computer System (MMACS). This information combined with other information gathered during our survey has lead us to request your participation in the national project.

Initially we have concentrated on three specific areas of concern:

1. Facilities that did not meet important conditions and standards as reported on MMACS. We selected 7 conditions and 25 standards we felt were most related to patient care and designed computer programs that identified facilities that did not meet one or more of our predetermined criteria relative to the conditions and standards.

2. Facilities that were not surveyed within the last 18 months. Federal law does not require annual surveys but Federal regulations were not changed. These regulations still require annual surveys. We identified many homes that, according to MMACS, were not surveyed within the last 18 months. We also found, however, that in Region III, HCFA did not always input data on nursing homes in the termination process. Therefore, the nursing homes we identified were either not surveyed or could be experiencing serious health and safety problems.

3. Facilities that were not fully surveyed. Federal regulations require that all conditions of participations be reviewed during the facility's annual survey. Our initial MMACS applications indicated that several states are reviewing selected conditions of participation.

In Region IX, we are interested in obtaining information on the first and third points. Our analysis has indicated that California has a relatively high number of facilities that did not meet important conditions and standards for a long period of time as reported on MMACS. Over 100 facilities in California met our criteria in the various categories. Also, our survey has indicated that California is performing "partial" surveys. As a start of the national review we would like to address these two areas.

I am providing as an attachment to this memorandum a short list of questions that we would like answers to. However, before contacting HCFA and the various state agencies I would appreciate it if your staff members assigned meet with the audit supervisor on my staff who will provide additional details and background information.

If you have any questions or wish to discuss this matter further, please contact me, or have a member of your staff contact James Maiorano of this office.

S. A. Rafalko

Attachment

Preliminary Questionnaire

Failure to Meet Specified Conditions/Standards Over a Period of Time

1. Determine latest status of each of the facilities identified.

2. Review files at HCFA to determine details on each facility (or a sample if need be). We should be looking for things such as:

   ... how long have the identified deficiencies existed.

   ... what actions have been taken, or are planned, to improve facility or remove it from participation (Both by HCFA and state).

3. Determine at the State Agency the status of each of these facilities. Has all information been forwarded to HCFA.

4. Would a site visit to facilities be warranted? Is there a need for outside consultants (medical or other) to get involved?

Partial Surveys (California)

1. Determine why the state of California is performing only partial surveys.
2. Under what authority is California acting.
3. Is HCFA aware of this practice?
4. If the partial surveys are being done with knowledge and approval from HCFA what were they trying to accomplish?
5. What criteria was used to develop the strategy for selecting the specific condition that were included in the partial surveys. Were they consistent?
6. Has this process (partial surveys) been successful according to HCFA? According to California officials?
   a. Can cost savings be attributed to this action?
   b. Any changes in the quality of care or condition of facilities noted?

Attachment

SD

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Health Standards and Quality Bureau
1849 Gwynn Oak Avenue
Baltimore, Maryland 21207

NOV 21 1984

Mr. Conrad Thompson, Director
Bureau of Nursing Home Affairs
Department of Social And Health Services
Olympia, Washington 98504

Dear Mr. Thompson:

Thank you for again forwarding comments on the redraft of the termination procedures. They are comprehensive and insightful as were your earlier comments. I can assure you that these comments will be given full and careful consideration in any future reevaluation of the procedures regardless of whether the reevaluation takes place in a work group along the lines you suggest, or in some other format.

I agree that intermediate sanctions should be an integral part of the procedures. However, our General Counsel has advised us that implementing regulations are needed before this provision is incorporated as part of our operating manuals. That process is just underway and final rules will probably not be published much before the end of 1985.

The reasonable assurance provisions will be given the same careful scrutiny as the rest of the procedures, but we are convinced that the existing procedures, as currently being implemented, have not been effective enough in carrying out the intent of the law and regulations.

We have put the procedures on hold for the time being. Final procedures will not be implemented until all affected groups have had the opportunity to voice their comments and recommendations.

Sincerely yours,

Margaret VanAmringe

Margaret VanAmringe
Director,
Office of Survey and Certification

cc Bruce Ferguson
Carole Washburn
Jerry Reilly
PM's
Bill Gammon
Peggy Brown
W. H. Exec's
RETURN

RECEIVED
DEC 07 1984
DSHS - BNHA
SURVEY PROGRAM

RECEIVED
NOV 30 1984
DSHS
ADMINISTRATIVE REGULATIONS

[COMMITTEE STAFF NOTE: Summary of State Survey and Certification Agency responses to a questionaire sent out by the National Academy of Sciences' Institute of Medicine, under contract with HCFA.]

Survey of State Licensure and Certification Agency Directors

Form Approved
OMB No.:0938-0395

Instructions. This survey is being conducted by the Committee on Nursing Home Regulation of the Institute of Medicine, National Academy of Sciences. In order to provide a complete picture of each state's nursing home regulatory system to the study Committee, this questionnaire seeks information about state laws, organizations, staffing, workload, and procedures.

Please fill out the following questionnaire as completely as possible, and return it in the enclosed envelope by December 15, 1984. There are lines whenever short answers are required. There are parentheses whenever a check mark is required. Please use an "X" for the check mark. In order to complete the questionnaire, you may need to confer with others.

In the questionnaire, "survey agency" refers to the state agency which administers licensure and/or certification surveys of nursing homes, and "Medicaid agency" refers to the single state agency which administers Title XIX funds.

Thank you very much for your cooperation.

If you have any questions regarding the questionnaire, please call Mike McGeary at the Institute of Medicine (202) 334-2312.

1. Name of State:

2. Name of respondent:

3. Title of respondent:

4. Name of organizational unit headed by respondent:

5. Name of department in which unit is located:

6. Phone number of respondent (required in case clarifying information is needed):

HCFA-466

OMB No.:0938-0395

STATE:__________

A. Organization of Nursing Home Regulation Activities

7. Does the survey and certification unit do any of the following activities concerning nursing homes in your state:

	Activity	Yes/no	If no, name responsible agency and its dept.
a.	State licensure surveys of nursing homes?	46/1	
b.	Medicaid certification surveys?	46/0	
c.	Medicare certification surveys?	47/0	
d.	Inspection of care reviews?	17/29	
e.	Setting of Medicaid reimbursement rates for nursing homes?	2/44	
f.	Complaint investigations concerning nursing homes?	46/1	
g.	Life safety code inspections of nursing homes?	32/15	
h.	Certificate of need determinations	7/37	

8. Does your agency also survey any of the following types of health facilities?

	Facility type	Yes/no	If no, name of responsible agency
a.	Hospitals	44/3	
b.	Home health agencies	45/2	
c.	Hospices	45/2	
d.	Board and care/domiciliary/ rest homes	33/14	
e.	Supervised or congregate living facilities	13/33	

STATE: ___________

9. Are nursing home surveys officially delegated by your state to any city or county level government agencies?

a. (43) No.

b. (4) Yes, they are delegated to (do not include your own district office, please list): ____________________

B. Survey Agency Personnel and Budget*

10. What is the total number of all full-time equivalent persons in your survey agency? (Include those who work on other than nursing home surveys.)

Median = 43.5; Range = 3 to 530

11. What were your licensing and certificati(:penditures for all facilities for fiscal years 1980 and 1983 1984 (the most recent year for which you have data)?

FY ends**___:	1980		(check appropriate year) 1983 ( ) or 1984 ( )	
Budget category	Median	Range	Median	Range
a. SNF 18	101,139	3,346-1,689,724	117,970	2,327-2,486,881
b. Non-SNF 18	246,699	48,827-1,863,714	286,130	13,376-4,500,121
c. Total Title 18	240,743	65,820-3,533,838	307,113	36,123-6,494,925
d. Federal Title 19	396,425	41,000-4,294,143	411,115	51,876-3,673,755
e. State match for Title 19	56,915	2,913-2,129,361	209,773	11,633-3,244,319
f. Total Title 19	541,981	66,175-7,049,190	636,659	63,509-6,964,348
g. State licensure only	206,880	45,386-7,365,516	376,928	79,376-6,964,348
h. TOTAL	1,321,052	131,995-15,592,224	1,526,960	99,632-35,450,768

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*Please attach an organization chart of your agency and department.

**If your FY ends on a different date for each of the following questions, please note date; otherwise write S for same as listed in question 11.

OMB No.:0938-0395

STATE: ____________

12. Number of full-time equivalent employees engaged in all health facility licensing and certification activities in:

Position	FY ends: _____ 1980 Median	Range	(check appropriate year) 1983 ( ) or 1984 ( ) Median	Range
a. Surveyors	23	3-200	26	3-151
b. Others (e.g., supervisory, administrative, clerical)	13	2-114	14	2-114
c. TOTAL	48	6-250	44	6-246

13. Overall, what percentage of your state agency's total state survey and federal certification effort is devoted to:

	Median	Range	
a.	56 %	14-93	Nursing homes (SNF and/or ICF)?
b.	20 %	2-65	Other long-term care facilities and services (e.g., ICF/MRs, hospices, home health agencies, board and care/domiciliary/rest homes, congregate or supervised living facilities)?
c.	20 %	0-54	Other health facilities (e.g., hospitals, laboratories, ESRDs, etc.)?
	100 %		TOTAL

14. If your agency conducts inspection of care reviews, what were your expenditures in fiscal years 1980 and 1983 or 1984 (the year for which you have the most recent data)? Please leave blank if not cone in your agency.

Budget	FY ends: _____ 1980 Median	Range	(check appropriate year) 1983 ( ) or 1984 ( ) Median	Range
a. Title 19	540,721	17,419-6,575,526	570,066	77,570-8,506,510
b. State match	349,045	5,806-2,586,882	288,904	33,496-3,448,966
c. Total IOC expenditures	1,019,700	23,225-9,162,408	770,088	129,284-11,195,547

STATE: ____________

15. How many full-time equivalent employees in your agency were engaged in inspection of care review?

Position	FY ends:______ Median	1980 Range	(check appropriate year) 1983 ( ) or 1984 ( ) Median	Range
a. RNs	11	0-84	9.5	0-84
b. Social workers and others	9	0-373	5.5	0-268
c. Total FTEs	26	0-439	18	0-308

16. In addition to the personnel who carry out survey and inspection of care functions who are listed above, does your agency have personnel whose specific duties are to process enforcement actions against facilities or individuals who violate nursing home regulations? If yes, please indicate full-time equivalent positions on the appropriate line.)

	Response	0	1	2	3	4	8	11
a. Attorneys	# States	23	10	2	1	1		1
b. Hearing officers/admin. law judges		28	4	1	1			
c. Investigators		30	1	0	0	1		
d. Special assignment surveyors		30	1	0	0	0	1	
e. Other (specify): ______________________		____						

17. Does your agency have under state law a nursing home complaint and abuse reporting system?

a. (34) Yes.

b. (7) No, but such a system is operated by another agency (please specify): ________________________________

c. (6) No, there is no statutory complaint system.

18. If your agency handles nursing home complaints, are they investigated by:

a. (35) the regular surveyors?

b. (10) a separately staffed unit of _____ FTEs? Median = 5; Range = 1-30

c. (0) others? (please specify): ______________________

OMB No.:0938-0395 -6-- STATE: ________

C. Survey Agency Workload

19. How many noncertified nursing homes with SNF and/or ICF-like services did your agency license (as of September 1984) that have no federally certified beds?

Median = 7.5; Range = 0-211

20. How many visits to certified SNFs and ICFs did your agency make in 1980 and in 1983 or 1984?

FY ends: ______	1980		(check appropriate Year) 1983 ( ) or 1984 ( )	
Type of Visit	Median	Range	Median	Range
a. Full licensure or certification surveys	250.5	15-5,331	282	18-5,432
b. Abbreviated or partial surveys	0	0-105	0	0-708
c. Post certification revisits	268	0-1,827	187	0-2,280
d. Complaint investigations	151.5	0-5,371	142	0-7,218
e. Inspection of care visits	166.5	0-1,975	102	0-1,900
f. Other visits	59	0-1,157	76	0-6,004
Total	914	24-14,370	1,091.5	26-21,839

HCFA-466

21. In an average visit, how many person-days would your agency spend on site conducting the following activities in a nursing home of average size - approximately 100 beds - and quality? (E.g., a three person team spending two days in a facility would spend six person-days).

		SNF		ICF		SNF/ICF	
		Median	Range	Median	Range	Median	Range
a.	Certification and Licensure Survey(s)	6.8	1-18 days	5.9	1-12 days	6.5 days	1.5-20
b.	Inspection of Care	8	3-14 days	7.5	2-17 days	8.0 days	3-20
c.	Post Certification Revisits	2	.5-6 days	1.5	.5-6 days	2 days	.5-25
d.	Complaint Investigations	1	.4-2 days	1	.4-2 days	1 days	.4-4
e.	Other:	.5	.5-6 days	1	.5-6 days	1 days	.5-2

22. Do all the surveyors in your agency work out of the central office?

a. (24) Yes, they are all based at the central office.

Median = 4; Range = 1-17

b. (22) No, we have ___ field or district offices and/or Median = 0; Range = 0- staff who work out of their homes.

D. State Regulatory Standards

23. In comparison with current federal Conditions of Participation and standards, are your state's licensing requirements for skilled facilities:

a. (14) Exactly or about the same as the federal rules?

b. (14) Less stringent than the federal rules? Stringent means operationally defined and demanding. The major differences are: ______________________________

____

c. (17) More stringent than the federal rules? The major differences are: ______________________________

____

24. In comparison with current federal standards, are your state's licensing requirements for intermediate facilities:

    a. (11) Exactly or about the same as the federal rules?

    b. (12) Lower/less stringent than the federal rules? The major differences are: ________

    c. (24) Higher/more stringent than the federal rules? The major differences are: ________

E. Special Surveyor Training

25. Have your surveyors received "specific" training to better justify enforcement actions when necessary, including 1) how to prepare better documentation of evidence; 2) how to be a better participant/witness in enforcement proceedings; 3) how to work with the court, with the district or state attorneys, and hearing officers?

    a. (33) Yes. (If yes, answer question 26.)

    b. (14) No. (If no, skip to question 31.)

26. How many hours of such training does each surveyor receive in a year?

    7.5 Median Range = 1-96

27. Who conducts the training?

    a. (9) Staff internal to our agency

    b. (1) State staff external to our agency, e.g. the District Attorney's office

    c. (2) Outside consultants

    d. (22) Combination of the above

28. Who pays for the training? Where do the funds come from?

    a. (26) Line item in our budget

    b. (7) Included in another line item

    c. (1) Funds external to agency

OMB No.:0938-0393 STATE: ____________

29. Has the training assisted the surveyor to carry out his/her duties?

a. (33) Yes: comment, how ______________________

b. (0) No: comment, how ______________________

30. Should the training continue?

a. (34) Yes.

b. (0) No.

F. Survey Procedures and Coordination Arrangements

31. Are licensure and certification surveys combined?

a. (2) Our state only conducts the federal certification survey

b. (33) Yes, all the time.

c. (11) Yes, sometimes. Please explain: ______________________

d. (1) No, but they are both done by this agency on different visits

e. (0) No, our agency does one; another agency does the other

32. How frequently are facilities in your state given the full licensure and certification surveys?

a. All facilities are surveyed for licensure every __12__ months.

b. All facilities are surveyed for certification every __12__ months.

c. The time period between full surveys varies, depending on:

9 responses

33. If a full survey is not always given, do you use a screening or abbreviated survey to determine which facilities should receive a full licensure or certification survey?

    a. (7) Yes.

    b. (22) No.

34. During licensure/certification surveys, do surveyors conduct a "hands-on" assessment of residents?

    a. (33) Always, as as matter of agency policy.

    b. (12) Sometimes, if necessary to collect information.

    c. (2) Rarely.

35. Have you changed your licensure and/or certification survey procedures in recent years?

    a. (14) No.

    b. (33) Yes; the major changes are: ______________________________

    ____

    ____

36. Does your agency have written guidelines or policies and procedures on how surveyors should interpret State regulatory standards?

    a. (16) Yes. (If yes, please return a copy of the guidelines with this questionnaire.)

    b. (31) No.

37. When is the statement of deficiency form (HCFA 2567) completed?

    a. (3) At the facility, for the exit interview.

    b. (41) At the survey agency office within ___ days after the survey is completed.
    Median = 10; Range = 2-18

    c. (3) Other, explain: ______________________________________

    ____

38. Who has the authority to decide whether or not an F-number on the HCFA 1569 form or T-number on the HCFA 3070 form is not met, resulting in a statement of deficiency on the HCFA 2567 form?

a. (39) Any surveyor.

b. (3) The survey team leader.

c. (2) A supervisor.

d. (3) Other (please specify): ____________________

39. In surveying a nursing home for SNF certification, how many standards have to be deficient for the nursing services condition (F123) to be marked "not met"?

Check the appropriate box and explain if required.

a (2) any one
b. (1) 1
c. (2) 2
d. (1) 3
e. (0) 4
f. (0) 5
g. (0) 6
h. (0) 7
i. (0) 8
j. (0) 9
k. (5) only specific F's, namely Director of Nursing (3); twenty-four hour nursing (4); administration of drugs (3)
l. (36) it depends on ____________

____

40. Which of the following documents does a surveyor routinely review prior to conducting a survey? Check all that apply.

a. (45) previous licensure
b. (47) previous certification
c. (11) MMACS
d. (34) inspection of care reports
e. (42) complaints
f. (0) none of the above
g. (7) ombudsman reports
h. (16) other
i. ( ) total Median = 4; Range = 2-7

OMB No.:0938-0195 :STATE STATE: ____________

41. A number of agencies in addition to the survey unit collect or receive information about conditions in specific nursing homes. When information is received indicating that a facility is providing questionable care, what other units or agencies do you usually notify? Do they usually notify the survey agency when they receive information? Please check the appropriate boxes.

Agency	We Inform Them			They Inform Us		
	Yes Regularly	Yes Sometimes	No	Yes Regularly	Yes Sometimes	No
a. Medicaid Agency	36	8	1	29	12	3
b. State Ombudsman	14	24	6	21	24	2
c. Your own agency's complaint unit	27	2	0	23	3	1
d. Your own agency's consultant unit	19	2	4	20	4	1
e. Certificate of Need unit	7	13	16	11	8	15
f. Resident Advocacy Groups	4	9	25	6	20	13
g. State Department of Aging	10	21	8	12	26	3
h. HCFA Regional Office	35	11	0	34	9	1
i. Inspection of Care Unit	27	5	6	29	7	3
j. Medicaid Fraud Unit	12	26	4	6	25	6
k. Other:____________	5	8	1	4	8	2
____________	2	1	0	2	1	0

42. If your agency conducts inspection of care reviews, they are done:

a. (2) At the same visit as the certification survey.

b. (3) At a different visit.

c. (0) By the same team which conducts the certification survey.

d. (2) By a separate team.

Both a and c: 9
Both a and d: 0
Both b and c: 1
Both b and d: 3

43. Are inspection of care review findings cited as part of the documentation of deficiencies on the HCFA 2567 form?

a. (14) Yes (if yes, how frequently?):
   - i. (8) often/all the time.
   - ii. (5) sometimes/about half the time.
   - iii. (1) rarely/almost never.

b. (17) No.

G. Enforcement

44. Different states have different legal provisions for enforcing their nursing home standards. Below is a table that lists down on the first column several provisions. There are six other column headings labeled A through F. As instructed please complete columns A through F. For Column A, "State Has Provision," if your state has the provision, place a "y" on the appropriate line. If it does not, place an "n" on the appropriate line. Column B, "Recommending Agency," we are also interested if the survey agency and/or some other agency recommends the legal action. If your agency recommends the action, place a "y" on the appropriate line. If another agency recommends, write the name of the agency on the provided line. In many states different agencies determine whether the legal provision will be carried out depending on the sanction. For each sanction please list the appropriate agency or individual in Column C, "Deciding Agency." In Column D, "Number of Recommendations Carried Out," we would like to know the number of times the recommended actions were carried out in 1980 and 1983. Please write the numbers on the provided lines. In Column E, "Order of Importance," please rank order your perspective of the importance to the regulatory process of each of the provisions using the numbers 1,2,3 or 4 where

4 = Very important
3 = Important
2 = Unimportant
1 = Very unimportant

Finally, in Column F, "Order of Effectiveness," please rank order how effective you feel these provisions are in assuring compliance. Please rank each of the provisions using the numbers 1,2,3 or 4 where

4 = Very effective
3 = Effective
2 = Uneffective
1 = Very uneffective

If you do not use some of these sanctions, place an "X" on the line.

OMB 0938- 0395

	A	B		C	D		E		F
Legal Provision	State Has	Recommending Agency Survey Agency	Other (identify)	Deciding Agency	# States carrying out 1983		1983 Range of # actions taken	1983 Total actions	Effective/ Ineffective
Civil or administrative fines	26	24	1	17	13		2-450	900	19/5
Court-appointed receiver	21	19	3	8	8		1-4	12	15/3
State-appointed monitor	7	8	7	4	3		1	3	4/2
Suspension of all admissions	32	24	6	17	15		1-29	96	26/5
Consideration of past record in evaluation of certificate of need application	25	17	12	7	10		1-36	105	10/11
Court injunctions against substandard operation	37	36	1	17	9		1-3	13	19/11
State-initiated relocation of residents from substandard homes	36	31	5	21	14		1-8	27	22/8
Reduced Medicaid rates for inferior performance	9	6	12	3	1		10	10	4/2
Conditional or provisional licensing	35	34	2	22	14		1-72	268	23/8
Probationary license	15	14	6	8	5		1-72	154	9/3
Criminal penalties for patient abuse	30	16	14	9	5		1-300	376	13/11
License revocation	44	41	0	28	16		1-13	59	33/4
Involuntary decertification	40	39	1	22	13		1-55	129	26/7
Withholding of payments	19	8	14	5	3		4-263	272	13/2

per. state: Total sanctions available: Median = 8; Range = 1-14
Number of types of sanctions applied: Median = 2; Range = 1-12
Total number of sanctions applied: Median = 11; Range = 1-457

CFA 466

0938- 0195

	A	B		C	D		E	F
Legal Provision	State Has	Recommending Agency		Deciding Agency	Number of recommendations carried out		Order of Importance	Order of Effectiveness
		Survey Agency	Other (identify)		1980	1983		
Civil or administrative fines	___	___	___	___	___	___	___	___
Court-appointed receiver	___	___	___	___	___	___	___	___
State-appointed monitor	___	___	___	___	___	___	___	___
Suspension of all admissions	___	___	___	___	___	___	___	___
Consideration of past record in evaluation of certificate of need application	___	___	___	___	___	___	___	___
Court injunctions against substandard operation	___	___	___	___	___	___	___	___
State-initiated relocation of residents from substandard homes	___	___	___	___	___	___	___	___
Reduced Medicaid rates for inferior performance	___	___	___	___	___	___	___	___
Conditional or provisional licensing	___	___	___	___	___	___	___	___
Probationary license	___	___	___	___	___	___	___	___
Criminal penalties for patient abuse	___	___	___	___	___	___	___	___
License revocation	___	___	___	___	___	___	___	___
Involuntary decertification	___	___	___	___	___	___	___	___
Withholding of payments	___	___	___	___	___	___	___	___

STATE:____________

45. Does your agency have written guidelines on when or how formal enforcement action should be taken against a facility with deficiencies?

a. (20) Yes. (If yes, please return a copy of the guidelines with this questionnaire.)

b. (27) No.

46. Does your state have a law requiring mandatory reporting of patient abuse?

a. (38) Yes. b. (9) No.

47. Does your state have a law permitting residents to sue facilities to protect their rights?

a. (24) Yes. b. (18) No.

48. Does your state have other legal provisions which can be used to enforce quality of care standards?

a. (30) No. b.(16) Yes. Send copy or list: ____________________

____

49. Does your state have a system which rates nursing homes and publicly discloses the ratings?

a. (41) No. b. (6) Yes, it is operated by _Survey Agency______.

50. Do nursing homes with good compliance records (e.g., few deficiencies) receive higher Medicaid reimbursement rates or receive an incentive payment?

a. (6) Yes. b. (41) No. skip to question 52

51. What proportion of the homes in your state are currently receiving the higher rate(s)?

___30___% Median; Range = 28-32%

52. When you recommend court action, is there an attorney on staff to take care of this?

a. (13) Yes, the attorney is part of my agency's staff

b. (31) Yes, the attorney is part of the state or district attorney's staff but is assigned to my unit.

c. (3) No.

d. (0) Don't know; we have never requested court action.

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53. When you recommend court action, does the state attorney general carry out your request by filing suit?

    a. (20) All of the time

    b. (11) Most of the time

    c. (12) Some of the time

    d. (2) Don't know; we have never requested court action.

54. When you have taken a facility to court, do you think the courts have supported the agency's position?

    a. (3) All of the time

    b. (20) Most of the time

    c. (15) Some of the time

    d. (9) Don't know; we've never taken a facility to court.

The next several questions address the effectiveness of various enforcement efforts. For these questions effectiveness is defined as getting the facilities to comply with nursing home regulations, terminating contracts with facilities that fail to comply, as well as the speed and thoroughness with which the sanction is carried out; e.g. new admissions to the facility were stopped immediately on court order. You need to refer to your answers to question 44.

55. In general, would you say your agency or state enforcement efforts have been

    a. (15) Very effective?

    b. (29) Effective?

    c. (3) Not effective?

56. Why are the sanctions you ranked "number 4" listed in question 44, Column F, "Order of Effectiveness," effective?

    Affect income of provider (20)

    Quick implementation (7)

    Publicity (5)

    Ability to remove operator (4)

57. What are the obstacles to effective use of the sanctions you ranked "number 1" in question 44, Column F, "Order of Effectiveness?"

    Delays (11)

    Difficulty of Administering (3)

    Potential harm to residents (4)

    Small impact on provider income (2)

STATE: ____________

H. Views on Federal Regulations

58. The current federal Conditions of Participation for skilled nursing facilities:

    a. (8) Can ensure nursing home services of adequate quality as they are.

    b. (9) Can ensure nursing home services of adequate quality, if they deleted some unnecessary or unmeasurable provisions.

    c. (20) Could ensure adequate quality services if they included certain additions and modifications.

    d. (10) Cannot ensure adequate quality services without a major overhaul and reorientation.

59. The current federal standards for intermediate nursing facilities:

    a. (6) Can ensure nursing home services of adequate quality as they are.

    b. (8) Can ensure nursing home services of adequate quality, they deleted some unnecessary or unmeasurable provisions.

    c. (20) Could ensure adequate quality services if they included certain additions and modifications.

    d. (13) Cannot ensure adequate quality services without a major overhaul and reorientation.

    Which of the following statements do you feel is an accurate description of the situation in your state?

60. The current federal survey procedures:

    a. (11) Work reasonably well as they are in assuring that Medicare- and Medicaid-funded residents do not receive substandard services.

    b. (7) Would work as well if certain unnecessary or unmeasurable items were dropped.

    c. (7) Would work reasonably well if HCFA gave the states more support when they move to terminate substandard facilities.

    d. (20) Would work adequately if some changes and additions were made.

    e. (2) Need to be completely revised.

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61. Which, if any, federal survey and certification regulations (including both the Conditions of Participation and the Subpart S regulations) inhibit quality patient care?

Utilization Control (2)

62. Which, if any, federal survey and certification regulations (including both the Conditions of Participation and the Subpart S regulations) are currently ineffective and should be dropped completely?

Utilization Control (11)

Quarterly Staff Reports (5)

63. Which, if any, federal survey and certification regulations (including both the Conditions of Participation and the Subpart S regulations) should be retained in a modified or alternative form?

Nursing Services (5)

Medical Director (4)

Physician Services (4)

64. Which, if any, federal survey and certification regulations (including both the Conditions of Participation and the Subpart S regulations) are neither effective nor worth the time and cost?

Utilization Control (11)

65. List what you feel are the five most important federal survey and certification regulations (including both the Conditions of Participation and the Subpart S regulations) for ensuring adequate quality patient care?

1. Nursing Services (36)
2. Dietetic Services (30)
3. Pharmaceutical Services (24)
4. Physician Services (19)
5. Physical Environment (13)

66. What, if anything, should be in the federal survey and certification regulations (including both the Conditions of Participation and the Subpart S regulations) that is not there now?

Resident Assessment Outcomes (13)

Intermediate Sanctions (6)

Staff Ratios (5)

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67. The current requirement for annual surveys of all federally certified nursing homes should be made more flexible to permit less frequent surveys of facilities with histories of compliance and more than annual surveys of facilities with histories of noncompliance.

a. (12) Strongly agree	23
b. (11) Agree	
c. (10) Disagree	24
d. (14) Strongly disagree	

68. The time-limited agreement requirement should be dropped because its usefulness as an enforcement tool is outweighed by the consequent ability of facilities to predict the timing of survey visits.

a. (14) Strongly agree	28
b. (14) Agree	
c. (12) Disagree	19
d. (7) Strongly disagree	

69. A short screening instrument should be used in conjunction with more flexible survey cycles to identify which facilities should receive more frequent full surveys.

a. (11) Strongly agree	34
b. (23) Agree somewhat	
c. (6) Disagree	13
d. (7) Strongly disagree	

70. It is desirable and practical to include a patient-centered assessment in the certification survey process.

a. (30) Strongly agree	45
b. (15) Agree	
c. (0) Disagree	1
d. (1) Strongly disagree	

HCFA-466

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71. A sample of alert nursing home residents should be interviewed and their opinions be included as part of the survey process.

a. (10) Strongly agree)
) 18
b. (8) Agree)

c. (3) Disagree)
) 3
d. (0) Strongly disagree)

72. How many on-site visits should be required to verify correction with all items identified as deficiencies in a Statement of Deficiencies/Plan of Correction form?

a. (30) One on-site revisit is adequate and more practical in most cases.

b. (13) Several; there should be a series of on-site visits if there are multiple deadlines for corrections.

c. (3) None, because on-site visits are expensive and some common deficiencies can be adequately verified by telephone or mail.

73. Accreditation by JCAH or some other accrediting body should be permitted to stand in place of state surveys for federal certification purposes.

a. (1) Strongly agree)
) 1
b. (0) Agree)

c. (11) Disagree)
) 46
d. (35) Strongly disagree)

74. The federal regulations should require posting of survey results. The posting should include whether or not the facility is in compliance in general and list the specified elements found not to be in compliance. This posting should be in a prominent location in each facility.

a. (17) Strongly agree)
) 30
b. (13) Agree)

c. (13) Disagree)
) 17
d. (4) Strongly disagree)

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75. The regulations, procedures, and forms for surveying skilled and intermediate level facilities should be combined in to one comprehensive survey.

a. (18) Strongly agree)
b. (18) Agree) 36
c. (9) Disagree)
d. (1) Strongly disagree) 10

76. Should the inspection of care review system be integrated with the process of surveying nursing homes for certification?

a. (26) Yes, they both should be done at the same visit by different teams so that significant inspection of care problems can be cited and corrected in the survey process while the burden on providers is reduced.

b. (6) Yes, and to save costs and avoid duplication, they should be done by the same team as well as during the same visit.

c. (7) No, the two functions should be conducted by separate agencies or departments, because they have different foci (patient vs. facility) and/or two visits allow better surveillance of facilities.

d. (7) No, they are separate functions, but they should be under the same supervisor in the state health or health and human services department so that the pertinent findings of each process can be shared.

77. Federal regulations should contain a requirement for state certification of nurses aides.

a. (14) Strongly agree)
b. (20) Agree) 34
c. (10) Disagree)
d. (2) Strongly disagree) 12

STATE: ________

78. Specific minimum nursing staff to patient ratios should be adopted in the federal regulations.

a. (13) Strongly agree)
) 32
b. (19) Agree)

c. (13) Disagree)
) 15
d. (2) Strongly disagree)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Region X
M/S 409
2901 Third Avenue
Seattle, WA 98121

February 15, 1985

DIVISION OF HEALTH STANDARDS AND QUALITY
STATE LETTER NO. 170

SUBJECT INDEX CATEGORY: 2

SUBJECT: Long Term Care Time Limited Agreements

As a reminder, we have rescinded those parts of our State Letter No. 101, dated November 20, 1981, addressing time-limited agreements and resurvey intervals. The part covering the addition of specialties or services without a survey is still in effect.

The attached Medicare and Medicaid regulations require specific procedures for time limited agreements and for cancellation or non-renewal of these agreements. They remain, of course, in full force and effect.

If there are any questions about this subject, please contact your DHSQ State Representative.

Sincerely,

Thomas G. Wallner
Associate Regional Administrator
Division of Health Standards and Quality

Enclosure

MEDICARE

§ 405.1908 Special requirements applicable to skilled nursing facilities with deficiencies.

(a) Where the facility is not in full compliance with the standards contained in Subpart K of this part, the period of certification shall:

(1) Be restricted to a period that is no later than the 60th day following the end of the time period specified for the correction of deficiencies in a written plan which the Secretary has approved: *Provided*, That such period shall not exceed 12 full calendar months, except as provided in § 405.604(b); or

(2) Provide a conditional period of 12 full months, subject to an automatic cancellation clause, the certification will expire at the close of a predetermined date which is no later than the 60th day following the end of the time period specified for the correction of deficiencies: *Provided*, That such date will occur within such 12-month period, unless the Secretary determines that all required corrections have been satisfactorily completed or that the facility has made substantial effort and progress in correcting such deficiencies and has resubmitted in writing a plan of correction acceptable to the Secretary.

(b) If the facility continues to be out of compliance with the same standard(s) at the end of the term of the agreement, a new agreement may not be accepted for filing (see § 405.1904(b)).

(c) When an agreement with a skilled nursing facility is not renewed at the end of its specified term (including the automatic cancellation of agreement), see § 405.604(c) for public notice and the right to request review.

(d) If the later survey discloses that a skilled nursing facility that had standards out of compliance during the last survey is no longer in compliance with a standard that was previously met, a new period of certification may be approved only if, in the judgment of the Secretary, the deficiency(ies) has occurred:

(1) Despite adequately documented intensive efforts or for reasons beyond its control, the skilled nursing facility was unable to maintain compliance, and

(2) Despite the deficiency the facility is making the best use of its resources to render adequate care.

(e) If a skilled nursing facility can document to the State's satisfaction that it achieved compliance with a previously unmet standard during the period of certification but for reasons beyond its control, e.g., loss of key staff member, was found out of compliance by the time of the next survey, this may be treated as a new deficiency instead of a carry-over deficiency unless in the judgment of the Secretary the facility did not make a good faith effort to maintain compliance with the standard.

MEDICAID

§ 442.105 Certification with deficiencies: General provisions.

If a survey agency finds a facility deficient in meeting the standards specified under Subpart D, E, F, or G of this part, the agency may certify the facility for Medicaid purposes under the following conditions:

(a) The agency finds that the facility's deficiencies, individually or in combination, do not jeopardize the patient's health and safety, nor seriously limit the facility's capacity to give adequate care. The agency must maintain a written justification of these findings.

(b) The agency finds acceptable the facility's written plan for correcting the deficiencies.

(c) If a facility was previously certified with a deficiency and has a different deficiency at the time of the next survey, the agency documents that the facility—

(1) Was unable to stay in compliance with the standard for reasons beyond its control, or despite intensive efforts to comply; and

(2) Is making the best use of its resources to furnish adequate care.

(d) If a facility has the same deficiency it had under the prior certification, the agency documents that the facility—

(1) Did achieve compliance with the standard at some time during the prior certification period;

(2) Made a good faith effort, as judged by the survey agency, to stay in compliance; and

(3) Again became out of compliance for reasons beyond its control.

(e) If an ICF or ICF/MR has a deficiency of the types specified in § 442.112 or § 442.113 that requires a plan of correction extending beyond 12 months, the agency documents that the conditions of those sections are met.

§ 442.110 Certification period: General provisions.

(a) A survey agency may certify a facility that fully meets applicable requirements for up to 12 months.

(b) The survey agency may notify the Medicaid agency that the term of a provider agreement may be extended up to 2 months after the expiration date of the agreement under the conditions specified in § 442.16.

§ 442.111 Certification period: Facilities with deficiencies.

(a) Facilities with deficiencies may be certified under § 442.105 for the period specified in either paragraph (b) or (c) of this section. However, ICF's with deficiencies that may require more than 12 months to correct may be certified under §§ 442.112 and 442.113.

(b) The survey agency may certify a facility for a period that ends no later than 60 days after the last day specified in the plan for correcting deficiencies. The certification period must not exceed 12 months, including the period allowed for corrections.

(c) The survey agency may certify a facility for up to 12 months with a condition that the certification will be automatically canceled on a specified date within the certification period unless—

(1) The survey agency finds that all deficiencies have been satisfactorily corrected; or

(2) The survey agency finds and notifies the Medicaid agency that the facility has made substantial progress in correcting the deficiencies and has a new plan for correction that is acceptable.

The automatic cancellation date must be no later than 60 days after the last day specified in the plan for correction of deficiencies under § 442.105.

[COMMITTEE STAFF NOTE: On February 21, 1985, the Health Care Financing Administration published proposed rules for the "Intermediate Sanction of Long Term Care Facilities" in the Federal Register, page 7191.]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date FEB 25 1985

Sharon Harris

From Sharon Harris, Acting Director
Office of Survey and Certification

Subject Implementation of MMACS Front-End Data Entry and Case Control System

To Associate Regional Administrators
Division of Health Standards and Quality
Regions I - X

After reviewing your comments on our January 18 memorandum, we have decided to proceed with the implementation of a front-end data entry and case control system to promote national uniformity in the identification of providers for substantive review before recertification. Effective March 11, all recertification kits from the State agencies are to be entered into MMACS upon receipt in the regional office prior to review by the certification specialists. Until further notice, the front-end data entry portion of this system will apply only to recertifications. Regional certification specialists should continue to review all other types of actions (e.g., initials, CHOWS, revisits, adverse actions) prior to entry into MMACS.

Based on your comments and suggestions, we have made several modifications to the system as outlined in the attachments to the January 18 memorandum. These changes include:

- Critical Requirements

  We have decided to add to our original list of critical requirements the Conditions of Participation (COPs) for all provider types. (We will not add the standards for ICFs and ICFs/MR.) Regional Offices are free to supplement these mandatory flags with additional flags of their choice. However, at least during the initial evaluation period, we will not program the system to identify the additional flagged items. After we have gained some experience in using the system, we will reevaluate our original flags and consider programming additional central office and regional office flags.

- Certification Workflow

  For Medicare and Medicare/Medicaid providers, the entire recertification kit, with the exception of the determination approval date (L33), should be entered into MMACS upon receipt in the regional office. This involves a change in the existing method of front-end data entry used in some Regional Offices. Any State agencies doing direct data entry should also enter the entire kit with the exception of L33. All cases entered in this manner will go to the transaction (orbit) file until the L33 date is completed. This will allow the Regional Offices to make any necessary changes to the provider record, if necessary, before the kit is accepted to the master file. We are also revising the MMACS update screen to allow you to enter the L33 date more easily. For Medicaid only providers, the entire recertification kit, including L33, should be entered upon receipt in the Regional Office.

- Individual Facility Profile (IFP)

  We are revising the IFPs in order to permit easier identification of flagged cases. The upper right hand corner of the IFP will have a "FLAGGED PROVIDER" indicator. There will also be an indicator (#) beside all current COP or critical requirement deficiencies and deficiency counters will be built in to tally and display on the IFP the number of flagged deficiencies.

- MMACS Daily Report

  To provide you with a summary report on the number of providers flagged each day, the Receipts and Dispositions report will include an indicator (X) next to the flagged provider numbers and a total of these providers.

We plan to implement the case control system sometime this Spring. We are now developing reports to be used in this system which will apply at first only to initials and recertifications. The system will be expanded later to include other types of actions (e.g. follow-up visit reports).

We plan to evaluate the front-end data entry and case control system for approximately six months after its implementation. Your comments and feedback during this period will be instrumental in making the system as useful as possible for both the Regional Office and Central Office. Please direct any questions, comments, or suggestions in this regard to Barbara Slobodin at FTS 934-7942.

cc:
Philip Nathanson
Thomas Morford

Attachment A

4/25/85

Conditions of Participation (COPs) and Critical Requirements

Hospitals (L007 = 01) Provider Group 1

COPs	Data Tag	Identifier	Description
	A006	I	Compliance with State and Local Laws
	A009	II	Governing Body
	A021	III	Physical Environment
	A026	IV	Medical Staff
	A047	V	Nursing Department
	A073	VI	Dietary Department
	A091	VII	Medical Record Department
	A115	VIII	Pharmacy and Drug Room
	A126	IX	Laboratories
	A153	X	Radiology Department
	A162	XI	Medical Library
	A163	XII	Complementary Departments
	A190	XIII	Outpatient Department
	A195	XIV	Emergency Service or Department
	A199	XV	Social Work Department
	B006	XVII	Special Medical Records Requirement
	B038	XVIII	Special Staff Requirements

The following COPS apply when the facility is designated as Hospital-SNF swing bed (SF44:1).

A512	VII	(F249) Specialized Rehabilitative Services
A523	X	(F300) Dental Services
A531	XI	(F308) Social Services
A547	XII	(F324) Patient Activities

COP Total - 21

CRs	Data Tag	Identifier	Description
	A014	2B-3	All Patients Under Physician's Care
	A039	4L	Infection Committee
	A043	40	Review of Clinical Work
	A049	5A-1	Registered Nursing Services
	A068	5B-3	Administration of Medication
	A090	6D	Diets
	A144	9I	Blood and Blood Products
	A164	12A	Surgery
	A182	12B-2	Persons Qualified to Administer Anesthetics
	A197	14B	Emergency Medical Service Medical and Nursing Personnel
	A206	9K	(E032) Proficiency Testing
	A228	9L	(E087) Quality Control
	A506	2K-7	(F073) Free from Mental and Physical Abuse
	K9:B		Life Safety Compliance
	L237=13	(RADARS Conversion)	

Critical Total - 14

Skilled Nursing Facilities (L007=04) Provider Group 2

COPS	Data Tag	Identifier	Description
	F007	I	Compliance with Federal, State, and Local Laws
	F015	II	Governing Body and Management
	F090	III	Medical Direction
	F101	IV	Physician Services
	F123	V	Nursing Services
	F207	VI	Dietetic Services
	F249	VII	Specialized Rehabilitative Services
	F263	VIII	Pharmaceutical Services
	F286	IX	Laboratory and Radiologic Services
	F300	X	Dental Services
	F308	XI	Social Services
	F324	XII	Patient Services
	F335	XIII	Medical Records
	F359	XIV	Transfer Agreement
	F366	XV	Physical Enviroment
	F428	XVI	Infection Control
	F448	XVII	Disaster Preparedness
	F462	XVIII	Utilization Review

COP Total - 18

2/25/85

CRs	Data Tag	Identifier	Description
	F073	2K-7	Free from Mental/Physical Abuse
	F105	4B	Patient Supervision by Physician
	F134	5C	24 Hour Nursing Service
	F173	5E	Rehabilitative Nursing Care
	F181	5G	Administration of Drugs
	F189	5H	Conformance with Physician's Drug Orders
	F221	6B	Menus and Nutritional Adequacy
	F244	6G	Sanitary Conditions
	F287	9A	Provision for Laboratory Services
	F296	9B	Blood and Blood Products
	F370	15B	Emergency Generator for Life Support System
	F395	15D	Communication System
	F435	16B	Aseptic and Isolation Techniques
	F449	17A	Disaster Plan
	F457	17B	Staff Training and Drills
	K9=B	15A	Life Safety Compliance
	L237=13	(RADARS Conversion)	

Critical Total - 16

Intermediate Care Facilities (L007=10) Provider Group 2

Note: ICFs do not have requirements at the condition level; therefore, the CRs listed below will be the basis for the ICF flags.

CRs	T055	5A-1	Disaster Preparedness
	T094	12	Physician Services
	T096	13A-9	Health Services Supervisor
	T102	13A-9	Responsible Staff Member
	T105	13A-9	Nursing Service
	T106	14	Meals
	T112	14A-7	Therapeutic Diets
	T117	14A-7	Sanitary Conditions
	T123	15A-8	Conformance with Physician's Drug Orders
	T159	18A-6	Equipped with Resident Call System
	T165	18A-6	Isolation
	K9:B		Life Safety Code
	L237=13	(RADARS Conversion)	

Critical Total - 12

DEPARTMENT OF HEALTH & HUMAN SERVICES

Memorandum

Date March 1,1985

From Fred Halbig
HCFA Audit Manager-Region V

Subject Planned National Review of Survey and Certification Activities
at Skilled and Intermediate Nursing Facilities

To Jim Maiorano
Region III

In the memorandum from your office dated November 13,1984, subject as above, you provided a "preliminary questionnaire" which you requested that we address in Region V. On January 16 and 17,1985, staff from your office visited the Springfield office staff to clarify and provide additional information related to the November 13,1984 memorandum.

Essentially the "preliminary questionnaire" raised questions concerning (i) facilities identified on the Medicare/Medicaid Automated Computer System (MMACS) as not surveyed in the last 18 months and (ii) the partial surveys performed in Wisconsin. The results of our review of these two areas were as follows:

Facilities Not Surveyed in Last 18 Months. At the HCFA Office in Chicago and where necessary the State level, we followed up on a random sample of 100 of the 303 nursing facilities in Region V which were identified in early January 1985 as not being surveyed in the last 18 months. Our review disclosed that:

-Twelve of the facilities had surveys made and the results recorded on the MMACS under a different provider number than identified by Region III audit staff. Ten of the 12 facilities had switched from XIX only facilities to XVIII/XIX Facilities. The other two switched from XVIII/XIX facilities to XIX facilities. These switches necessitated the change in the provider numbers. HCFA Region V did not remove the old provider number from the MMACS file of active providers.

-Fifty-two of the facilities were surveyed in the last 18 months under the same provider number as identified on the MMACS. HCFA had a copy of the surveys. Prior to October 1984 HCFA Region V generally made it a practice to delay entering survey information on the MMACS until deficiencies identified on the surveys were corrected. This often resulted in a delay for many months before the survey results were recorded on the MMACS. In October 1984, HCFA-Region V changed its procedures (Attachment A) whereby surveys are now entered into MMACS immediately upon receipt.

-Thirty-one of the facilities did not have surveys performed in the last 18 months. The last surveys made for these facilities were identified on the MMACS. Twenty-seven of the 31 facilities were located in the state of Indiana. We recently completed an audit of the certification of nursing facilities in Indiana . We will be issuing a draft report shortly in which we will be questioning FFP claimed under Title XIX for facilities which were not properly surveyed and certified. See Attachment B for a draft PAM on the subject.

The remaining 4 of the 31 facilities not surveyed in the last 18 months were located in the state of Wisconsin. Under that state's plan each nursing facility was not expected to be surveyed every 18 months.

-Two of the facilities were Christian Science facilities. HCFA-Region V does not get involved with the certification of these facilities. We were advised that they are certified by the First Church of Christ Scientist in Boston, Massachusettes.

-Three of the facilities were closed or were no longer operating as SNF's; therefore, surveys were not late. HCFA-Region V did not remove the provider from MMACS file of active providers.

The above results for the 100 sampled facilities identified by state are as follows:

	State						
Category	IL	IN	MI	MN	OH	WI	Total
Change in Provider Number	4			4		4*	12
Entry of survey data delayed by HCFA-Region V	22	2		10	14	4*	52
No Survey Performed		27				4	31
Christian Science Facility			1		1		2
Facility Closed or no longer SNF			1			2	
Total	26	29	2	14	15	14	100

*Includes some partial surveys

It should be noted that, while the 64 facilities (12 plus 52) that had surveys performed did have deficiencies cited, none of them were of the type that resulted in the nursing facilities meeting one of the following three criteria used by Region III in identifying potentially deficient facilities:

-Failure to meet any one of the listed Conditions of Participation for two or more consecutive years since 1979.

-Failure to meet three or more listed Conditions in any one of the last three most recent surveys.

-Failure to meet any one of the listed Conditions of Participation four or more times.

In summary, with the exception of surveys not performed in Indiana, we do not believe that the problems disclosed by our review are a sign that substandard homes are allowed to continue in the program undetected or that surveys are late.

Partial Surveys (Wisconsin Only). Answers are in response to the six questions raised in your questionnaire.

1. For the period from July, 1981 to July,1983 Wisconsin's plan for surveys of SNFs and ICFs (Attachment C) called for variable survey schedules. Generally, facilities identified as "problem" facilities were surveyed annually. Those XVIII/XIX facilities considered as not "problem" facilities were surveyed at least once every two years. As a part of this two year survey, partial surveys were made of the facilities' problem areas to monitor correction of problems and continued compliance. Reportedly, Wisconsin went to the variable survey schedule as a result of a reduction in funds available to do surveys of SNF facilities participating in the Medicare program. In August, 1983 Wisconsin began again its past practice of surveying all facilities on an annual basis.

2. The variable survey schedules were authorized for SNFs under Section 2153 of the Omnibus Reconciliation Act of 1981 which repealed the mandates that agreements with SNF facilities be limited to a duration of 12 months. HCFAs guidance (Attachment D) extended this flexibility, in certain circumstances, to Medicaid as well.

3. HCFA-Region V was aware of Wisconsin's practice of performing partial surveys.

4. See answer in 1 above and Attachment C.

5. The criteria used to develop the strategy for selecting the specific conditions that were included in the partial surveys is identified in Attachment C. This criteria appears to have been consistently applied.

6. Concerning the success of the partial surveys, HCFA-Region V officials have no basis to form an opinion. Wisconsin officials believe that, while survey costs were reduced during the period of partial surveys, the overall condition of nursing facilities may have worsened during that period. Wisconsin officials believe that the annual surveys are a better tool for ensuring quality care than partial surveys.

In accordance with your verbal request on February 28,1985, we have discontinued any further efforts concerning your "preliminary questionnaire".

Attachments (4) [COMMITTEE STAFF NOTE: Attachments "A" and "D" are located elsewhere in this chronology of DHHS internal documents.]

[COMMITTEE STAFF NOTE: Draft Priority Audit Memorandum attached to March 1, 1985 memo from Region V OIG Audit office to Region III OIG Audit office.]

DEPARTMENT OF HEALTH & HUMAN SERVICES

ATTACHMENT G

Memorandum

Date

From Richard P. Kusserow
Inspector General

Subject PRIORITY AUDIT MEMORANDUM - Review of Title XIX Certification Agreements for Intermediate Care Facilities (ICF) and Skilled Nursing Facilities (SNF) Administered by the Indiana Department of Public Welfare for the Period June 1, 1982 to March 31, 1984. ACN 05-50150.

To Carolyne K. Davis, Ph. D
Administrator
Health Care Financing Administration

This memorandum is to alert you to significant findings disclosed during our audit of Title XIX Certification Agreements for ICFs and SNFs administered by the Indiana Department of Public Welfare.

The Code of Federal Regulations (CFR), Title 42 Chapter IV, Subchapter C, set forth State plan requirements, standards, and conditions for obtaining Federal financial participation (FFP) in payments for services provided under the Medicaid program. FFP is available in expenditures for SNF and ICF services only if the facility has been certified as meeting the required conditions for participation.

The regulations state, in part, that:

> ...(a) Certification and recertification...a Medicaid agency may not execute a provider agreement with a facility for SNF or ICF services nor make Medicaid payments to a facility for those services unless the Secretary or the State survey agency has certified the facility under this part to provide those services....

The regulations further state that, the survey agency must perform on-site inspections of a facility at least once during each certification period; the duration of a provider agreement may not exceed 12 months; and the provider agreement must be for the same duration as the certification period set by the survey agency. In Indiana, the medicaid agency is the Department of Public Welfare while the survey agency is the State Board of health.

Our review disclosed substantial non-compliance with both certification and provider agreement requirements of the Medicaid program. We identified a total of 230 facilities, out of the 347 facilities reviewed, that operated without effective certification for varying periods of time between June 1, 1982 and March 31, 1984, because the survey agency had not conducted the recertification surveys required for participation in the Medicaid program.

Payments made to these facilities during the time they were not certified to participate in the Medicaid program totaled about $70.4 million. The Federal share of these payments totaled about $41.3 million.

We plan to recommend that the medicaid agency make a financial adjustment in the amount of $41.3 million. We also plan to make procedural recommendations regarding compliance with the certification agreement regulations.

We expect to issue our draft report in March 1985.

cc: Majka
Mitchell
McGowan
Tyson
Siguler
O'Shaughnessy
Morey
Scott
Nelson
Vengrin
Nicholson
Haskins
Boyd
Mangano
Britten
Piazza
RiGAs

-Participating in the initial surveys and follow-up visits for Ambulatory Surgical Centers and Comprehensive Outpatient Rehabilitation Facilities. Since these are new programs, the number of surveys to be completed during 1984 is unknown.

-Provide inservice training, expert consultation and rule interpretation to other Bureau of Quality Compliance staff.

Long Term Care Section

The Long Term Care Section is primarily responsible for performing certification and licensure surveys, and for completing the Title XIX Inspection of Care Program. Survey activities for nursing home licensure and Title XVIII/XIX certification will be conducted at approximately 65% of the 487 nursing homes annually. A full survey will be conducted at least once every two years in all facilities. ICF/MR facilities will be surveyed on at least an annual basis per federal requirements. The basis for selecting facilities for survey is described elsewhere in this report (see attached criteria for ranking), and uses the inspection of care process to help identify facilities requiring more detailed attention by the Bureau. The completion of annual IoC's for the 37,000 medical assistance residents in Wisconsin nursing homes provides an additional monitoring mechanism to detect serious problems.

Complaints remain one of the highest priorities of the long term care program. The long term care section maintains the capability for immediate response to serious complaints, but also considers alternatives to immediate on-site investigation, for those complaints that offer minimal threat to patient welfare and safety, in order to maximize the efficient use of field staff. Surveillance is utilized to ensure continued correction of problems in facilities with a history of short-term compliance.

Inservice/consultation efforts focus upon needs identified by survey staff or related to correction of violations, rather than to formal requests for inservice from facilities in order to meet inservice or continuing education requirements. Facilities are encouraged to seek special consultation from outside resources which is complementary to the Bureau's regulatory role.

The Department of Health and Social Services is developing a requirement that each SNF be certified for Title XVIII. 176 initial Title XVIII SNF surveys may result from this requirement during FY 1984.

Bureau of Quality Compliance
Variable Schedule for Surveying SNF and ICF Facilities - Health Facilities Surveys (RN, SW and RS)

For FY 1984, the Bureau of Quality Compliance will again be required by budget constraints to reduce health facilities surveys for SNFs and ICFs. The Bureau will identify and target facilities with poor compliance histories for annual resurveys, while resurveying facilities with a good compliance history only once every two years. In addition, the Bureau will direct more staff time to performing complaint investigations, partial surveys and/or surveillance visits for facilities with a marginal or poor history of compliance. The Bureau uses a combination of an objective assessment of compliance history, tempered by subjective impressions of surveyors, to establish survey priorities.

The Bureau of Quality Compliance intends to complete a full health survey (including a nurse, social worker and sanitarian on the survey team) for at least 65% of the facilities scheduled for annual survey in a given month. Other facilities with historical compliance problems in a particular service delivery area (e.g., dietary, pharmacy, etc.) may receive partial surveys.

The following guidelines establish survey priorities.

1. Every certified facility will have annual IoC's performed on Title XIX residents in the month currently established by the master survey schedule.

2. All ICF/MR's (Community Based Residential Facility or Nursing Home) will have a full federal certification survey at least annually, based on the current master survey schedule.

3. All state licensed nursing homes and community based residential facilities will have a state licensure survey at least once biennially.

4. All federally certified SNF's and ICF's will have a federal certification survey at least once every two years.([illegible])

5. State licensure and federal certification surveys will be conducted during the same visit by the same inspection team.

6. Facilities identified as "problem" facilities (see Attachment A) will have full health facility licensure and, if certified, certification surveys at least annually.

7. Partial or interim surveys and/or surveillance visits, focusing on the facilities' problem areas, will be used to monitor correction of problems and continued compliance.

8. Complaint investigations will be prioritized and scheduled for investigation, based on the seriousness of the allegations.

Scheduling

Advance scheduling will be initiated two months in advance of the month to be scheduled. For example, during the first week of July, a rough schedule is developed for the month of September.

In advance of the monthly scheduling meeting, the Field Operations Manager will request a list which will show all activities tentatively scheduled for the given month. The list will show activities of high, medium and low priority. The Field Operations Manager will use the list to assign specific team members to daily activities to be performed during the month. Activities are scheduled by high priority, followed by medium priority, and lastly, low priority.

The Field Operations Manager will forward copies of the schedule to the central office (Madison) scheduling coordinator within three days of the scheduling meeting.

The central office scheduling coordinator will review all schedules to:

1. Ensure that all priority activities are scheduled;
2. Ensure that the Field Operations Managers are scheduling in accordance with the guidelines;
3. Monitor workload distribution and recommend changes of assignments to balance workloads.

Changes made to the survey schedule will be reviewed by the central office scheduling coordinator and approved by the Long Term Care Section Chief. If surveyor time is available, or needed, in a district, the central office scheduling coordinator will balance schedules accordingly. Final decisions regarding scheduling changes, facility reassignments and workload balance will be made at the monthly Field Operations Managers' meeting.

Post Survey Summary

After each full team (RN, RS, SW) survey, but prior to the exit conference, the Field Operations Manager, as schedules permit, will meet with the team members to evaluate the survey findings, review violations/deficiencies to be cited, and make recommendations for the scheduling of the next full survey, partial surveys or surveillance visits by one or all surveyor disciplines.

Identifying Problem Facilities

Objective Data

The criteria which comprise the "objective data" are the historical, "hard" facts about a facility which are readily obtained from the computer tracking system. The criteria used includes:

(a) Total Class A and B Violations/*Deficiencies.

(b) Total Number of Violations/Deficiencies. The total number of violations can indicate the scope of problems at the facility.

(c) Number of Uncorrected Violations/Deficiencies. The number of uncorrected violations/deficiencies indicates the facility's diligence and willingness to attain and maintain compliance.

(d) Number of Substantiated Complaints. The number of substantiated complaints indicates the facility's efforts to maintain compliance between scheduled survey visits.

(e) Number of Unsubstantiated Complaints. The number of unsubstantiated complaints can be an indication of the facility's efforts to maintain compliance.

In order to properly reflect a good or bad facility, Bureau of Quality Compliance staff ranked the above criteria on a scale from 1 to 5, with 5 reflecting the best indicator of a problem facility. Based on this ranking process, each objective criteria was weighted based on its proportion to the total number of possible points.

The following is the current weighting system:

Total Number of Class A & B Violations: = 10
Total Number of Violations: = 7
Number of Uncorrected Violations (including violations cited by engineer surveyors) = 6
Number of Substantiated Complaints: = 6
Number of Unsubstantiated Complaints: = 4

*A Class "A" violation creates a condition or occurrence relating to the operation and maintenance of a facility presenting a substantial probability that death or serious mental or physical harm to a resident will result.

A Class "B" violation creates a condition or occurrence relating to the operation and maintenance of a facility directly threatening the health, safety or welfare of a resident.

A facility's total rating is calculated by totaling the points it received for each criterion. These criterion are calculated by locating the facility's record in that criterion area over the previous 12 months on a graph and chart, determining the attached point value, and multiplying that value by the weight assigned to that criterion.

In addition to the five criteria used to rank facilities, other objective data is considered when determining when and how often to survey a facility, such as IoC results or changes in facility status. (e.g., Changes in ownership, etc.)

Subjective Assessment

In addition to using objective data to determine survey schedules, the subjective assessment of a home by surveyor staff is considered, and in some cases, indicates when to survey a facility.

The following is a list of subjective areas, not directly related to the codes, that may indicate when to survey a facility.

1. Management

   -effective management evident?
   -good communication among department heads?
   -good communication among staff within department?

2. Attitude Towards Correction

   -borderline compliance with the codes?
   -attitude toward problem identification by the state?
   -receptive to consultation, willing to try new ideas?

3. Quality of Resident Care

   -resident satisfaction with care?
   -good interaction among residents?
   -residents appear open, willing to talk?
   -resident attitude toward staff, good communication noted?

Facilities Regulation Section

The Facilities Regulation Section is responsible for coordinating all of the Title XVIII and XIX certification of providers of services in the state. Whenever a provider is determined to not comply with the regulations, this Section recommends appropriate adverse action.

```
SYSTEM FUNCTION - APPLICATION CODE:  5220
APPLICATION CODE TITLE: PROGRAM MONITORING

BUDGET SOURCE(S): 051101

DATA PROCESSING FACILITY(IES): 10000
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[COMMITTEE STAFF NOTE: HCFA sent this evaluation of the MMACS database to the Office of the DHHS Assistant Secretary for Management and Budget.]

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                        DEPARTMENT OF HEALTH AND HUMAN SERVICES
                          HEALTH CARE FINANCE ADMINISTRATION
                      OFFICE OF MDCL REVIEW

REPORT DATE: 03/13/85

DHHS ID NUMBER: FPE4  001                    DATE UPDATED/ENTERED: 00/00/00

SYSTEM TITLE:
MEDICARE/MEDICAID AUTOMATED CERTIFICATION SYSTEM(MMACS)

GAO ACCESSION NUMBER: 00524027
OMB REPORT NUMBERS:   0938-0043

RESPONSIBLE OFFICE: OFFICE OF STANDARDS & CERTIFICATION

PHONE NUMBER: (301) 594-2995      SYS MGR:

SYSTEM DESCRIPTION:
   MANAGE CERT. PROCESS FOR ALL MEDICARE/MEDICAID
FACILITIES. INPUTS: APPLICATIONS FOR PROGRAM PARTICIPATION
CERTIFICATION KITS & SURVEY FORMS. DATA IS ENTERED DAILY. AN
UPDATE IS PERFORMED & INFORMATION RETURNED TO RO'S WITHIN 24 HRS.
DATABASE CONTAINS MEDICAL CAPABILITIES & CONSTRUCTION PROFILE &
PATIENT CARE & WELFARE OF EACH FACILITY.  M I REPORTS ARE
GENERATED DAILY - BI-WEEKLY - MONTHLY & QUARTERLY.  ON-LINE
ACCESS TO PROVIDER HEALTH LIFE/SAFETY DEFICIENCIES & FACILITY
CHARACTERISTICS THROUGH RADARS QUERY RESPONSE SYSTEM.
AUTHORIZATION: PL 89-97.

RES SUMMARY       FY84     FY85     FY86     FY87     FY88     FY89     FY90

TOT RES($000)      801      779     1091      853        0        0        0
WORK YRS(FTE)     17.6     17.6     17.6     17.6      0.0      0.0      0.0

LIFE CYCLE - START DATE: 03/01/75   SYSTEM STATUS:     OPERATIONAL
               END DATE: 09/01/87   OPERATIONAL DATE: 03/01/75

EVALUATION SCHEDULE - LAST EVALUATION:          03/30/82
                      NEXT EVALUATION SCHEDULE: 04/26/85

SYSTEM SECURITY SENSITIVITY: LOW          FIPSPUBS:

SYSTEM CONTAINS PRIVACY INFORMATION? NO
     HAVE NOTIFICATION REQUIREMENTS BEEN MET? NOT APPLICABLE
     PRIVACY ACT IDENTIFICATION NUMBER:

A76 REQUIRED? NO         A76 COMPLETED? NOT APPLICABLE

SYSTEM FUNCTION - APPLICATION CODE:  5220
APPLICATION CODE TITLE: PROGRAM MONITORING

BUDGET SOURCE(S): 051106

DATA PROCESSING FACILITY(IES): 20202      10000
```

DRAFT

COPY
1985
REVIEW

SYSTEM EVALUATION SUMMARY

MEDICARE/MEDICAID AUTOMATED CERTIFICATION NETWORK

Systems Included: FVC001 - Medicare/Medicaid Automated Certification System

FVC003 - Provider of Service Data

Date Operational: FVC001 - 1975

FVC003 - 1968

Providers of Services: Health Care Financing Administration
Bureau of Data Management and Strategy

Annual Cost: FVC001 - $897,000*

FVC003 - $ 8,000

Total - $905,000**

Systems Manager: Michael Moran (594-7940)
Health Standards and Quality Bureau (HSQB)
Office of Survey and Certification (OSC)

Summary: See Attached

* This total was for FY 1982, the total cost for FY 1984 has been estimated to be less, because of the hardware change from Univac 1108, to IBM 4341, and use of CICS software procedures to support data entry and front-end editing. Exactly how much less is not available at this time, because the cost accounting system (at the HCFA Data Center) is still being developed and as of this date cannot isolate these specific costs.

** See * above

Medicare/Medicaid Automated Certification Network

Purpose of System

The Medicare/Medicaid Automated Certification System's primary objective is to support the certification process by maintaining accurate, complete and current information on all medical facilities participating in the Medicare or Medicaid Programs.

The informational contents of the data base are used by HSQB, BDMS, RO's and the various State Health Agencies in determining the eligibility of facilities to participate in either the Medicare or Medicaid Programs. Various reports generated from the data base are used as aids in scheduling recertification surveys of facilities, general administrative functions, and also in efforts to raise the general level of patient care.

Extracts from this data base are used by various other government agencies to obtain statistical data to determine the adequacy of the nation's current medical resources and project future medical service requirements.

Background/Historical Development

The Medicare amendments in 1966 created a need for information on medical facilities. To meet these needs, the Provider of Services (POS) file was created. This file holds information relating to the medical resources of a facility.

In 1969, the Bureau of Health Insurance developed a system to certify and determine the eligibility of medical facilities to participate in health care programs.

Through 1972, the method of processing was to receive numerous forms by mail from the regions. The forms were categorized and processed through either the POS system or the Survey Report system. There was a repetition of work and considerable redundancy of data in files and outputs.

In an effort to alleviate some problems, the 1972 Congressional amendments were passed. A maximum of 90 days from date of application to completion of the certification process was allowed. Thus, a complete profile of each facility's capabilities, resources, and deficiencies would be available for public disclosure within 90 days. MMACS was designed to meet the requirements of the 1972 Amendments.

In 1975, the Rapid Data Retrieval System (RADARS) was developed. RADARS is an on-line data base which allowed the regions to access codified MMACS data and generate ad-hoc reports on demand. In July 1981, an expanded version of RADARS was released for regional office use. It contains all master file data elements, provides flexibility in the generation of reports and supplies specific data rather than range codes.

In 1984, the ultimate goal the upgrade of MMACS to a "State-of-The-Art" system was achieved when the MMACS Master file was migrated to the IBM 4341. This allowed the data base to be placed on line providing the users will demand access to all data items contained in the CO data base. This access is available through the HCFA telecommunications network (Central Office And Regional Dispersed Terminal - CORDT).

Schedule Requirements

Information is collected regionally and transmitted to Central Office daily. All data received by 4:00 p.m. is processed and subsequent reports are transmitted to the regions by the following morning. Twenty-four hour turnaround allows the regions to use the reports generated by the system to determine if a facility should be denied certification.

Monthly land quarterly reports include all data processed by the system through the day preceding the last processing day of the month. All reports must be generated and transmitted to the regions by the 10th of the month. This allows for the timely distribution of reports to the State Agencies for use in scheduling facilities for resurveys.

Special Security Consideration

A. Program Backup

Test, production and backup versions of each program in the daily update process are maintained on a mass storage program file. All files are backed up daily by the Office of Computer Operations, BDMS, HCFA and retained for 30 days.

All bi-weekly, monthly, and quarterly programs are released for production through a central control section to the Office of Computer Operations. CICS programs are copied to production program files once a week and programmers are notified after the copy has been completed.

B. Data Backup

The Medicare/Medicaid Automated Certification System maintains a file of all medical facilities participating in the Medicare/Medicaid Programs. The input forms are stored in the regional offices and state agencies. The retention period varies from 3 years to indefinitely depending on the region. The MMACS master file is retained for 180 days, while the Provider of Services (POS) extract file (PH0749) is retained indefinitely. All MMACS data is stored in a secure tape library.

C. System Design Security Measures

1. Pac-F Systems Security Software
2. Access Codes/Passwords
3. Regional offices are only authorized to input or access data from their region.
4. All requests for substantial processing changes are completely documented.
5. MMACS data is available to the public through publications and special requests.

Overall Systems Description

The MMACS data base contains information on over 42,000 medical facilities which are broadly divided into eight separate categories depending on the type of medical service the particular facility offers. The broad categories are Hospital, Skilled Nursing Facilities, Intermediate Care Facilities, Institutions for the Mentally Retarded, Home Health Agencies, Independent Laboratories, Physical Therapists, Portable X-ray, Chronic Renal Dialysis, Rural Health Clinics, Comprehensive Outpatient Rehabilitation Facilities, Ambulatory Surgical Centers, Hospices, Physical Therapist in Independent Practice Hospitals and Extended Care Facilities are further divided into sub-categories indicating the type of patient care being offered.

Each medical facility record in the data base is composed of multiple variable length segments within the provider, with each segment having a distinct type of information and its own Record Identification Code (RIC).

The "P" RIC, Provider of Services (POS) segment, contains information relating to the medical capabilities of the particular facility with Name, Address, and Geographic Codes; this segment is used extensively in all Health related processing and for statistics and tabling.

The "R" RIC, Survey Report Form (SRF) segment, contains detailed information on all aspects of the facility related to patient care and welfare, and this segment is used primarily in the certification process for determing eligibility to participate in the Medicare or Medicaid Program.

The "S" RIC, Life Safety Code (LSC) segments, contain detailed information on construction and type of each building, wing and annex of the overall facility as it relates to patient safety. The information contained in this segment is used in certifying or denying a specific building for use in the programs.

The POS, SRF, and LSC data are collected periodically by the State agencies through on-site surveys. Their findings are recorded on Certification and Transmittal, application, resurvey, building, and plan of correction forms for the type of facility being surveyed.

The completed forms are forwarded to the HCFA regional offices where they are reviewed and the contents of the forms are keyed on ITT COURIER terminals.

On a daily basis, each region transmits the data to the IBM 4341's at the HCFA Data Center in Woodlawn where the data from all regions is collected and stored. On a nightly basis, the information transmitted from the regions is processed against the MMACS OCOO.PCDMB.HH200401 in a series of editing and updating operations on the IBM 4341's. After processing is completed, the supplemental data generated in the field has been divided into three categories:

1. Rejected - Receipt and Dispositions (Phase II)

2. Orbitted - Input data errors/or inconsistencies (Phase III)

3. Accreted - Individual facility profile (IFP)

A complete profile of each facility and a complete analysis of the data submitted are generated and transmitted from the IBM 4341's to the region's Datapoint terminals.

In the morning, each region receives an analysis of the information for facilities submitted the previous day.

On a monthly and quarterly basis, each region also receives reports and listings indicating the status of the various facilities in their area, for example, facilities requiring resurvey or revisit within any particular month.

An index of forms used in the certification process and a copy of the Medicare/Medicaid Automated Certification Brochure, which provides users with fundamental guides to the interpretation of MMACS data outputs, are attached and identified as TAB A and TAB B, respectively.

Evaluation Findings

The system was designed to reduce the amount of regional office staff time required (manual review of current/prior survey findings) to complete the certification or recertification of health care providers and supplies; and to establish a centralized data source which would provide information on the quality, quantity, and availability of health care related services in the United States. The original requirements and objectives of this network are still valid and are being satisfied efficiently.

Through the use of the system, we have been able to:

- expedite the SA survey documentation review process in the RO, by providing computer generated current/prior deficiency comparisions (Individual Facility Profiles);
- provide for scheduling/completion of required surveys in accordance with disclosure of information requirements;
- provide for the efficient/economical assessment of RO's - Regional Office Program Evaluation System (ROPES) and State survey agencies - State Agency Evaluation Program (SAEP) certification operations;
- maintain uniformity in the certification decision process;
- prepare OSC management reports to advise RO's and SA's of weaknesses or bottlenecks in their operations;
- identify certification problems which require additional training, modification of operating practices or revision of regulations;

Evaluation Findings

- provide information to the Office of the Secretary, Congress, and numerous other sources, on certification information; and

- provide facility characteristics for statistical reports and analyses by the Bureau of Data Management Strategy and (most recently), apply screening criteria for determining the frequency of provider surveys, necessitated by recent reductions in SA budgets.

System enhancements have been implemented on an ongoing basis and resulted in improved efficiency of the provider certification process as well as providing timely and quality information to all users of the network. For example, the estimated FY '81 M/MACS system cost of $1,250,000 decreased to $897,000 for FY '82 due to enhancements resulting in improved data transmission and data element input. Data transmission was changed to eliminate the use of Data Management Center services, thus cancelling an interagency services contract for M/MACS. Limiting data element input to the masterfile to include only critical data needed for certification operations resulted in substantial reduction in the data keyed and transmitted to Central Office by the regional offices.

The transfer of the CO processing operations, which began in FY 1983 and was completed in FY 1984, to the HCFA Data Center and software conversion to CICS procedures for data entry and front-end editing have resulted in additional reductions in the yearly operating expenses of MMACS.

System management/documentation and equipment operations are appropriate for this activity. The overall operation of the network is satisfactorily monitored through review of output products and through meetings of user groups which include RO and Central Office personnel. These meetings help assure that each user is receiving proper support and that needed system changes are implemented timely and properly coordinated.

(A copy of the questionnaire used in this evaluation and the documentation resulting from its application are located at TAB C.)

Recommendation

Based on the accomplishments and benefits discussed above, which are a direct result of the automated provider certification network, and overall user satisfaction, we recommend the operation of these systems (FVC001 and FVC003) be continued.

Approved:__________________________ Date:__________________________
System Manager

Approved:__________________________ Date:__________________________
Chief
Systems Evaluation Branch
SPPS

CERTIFICATION FORMS INDEX

Survey Report Form

Form Number	Form Description
HCFA-30	Rural Health Clinic Survey Report
HCFA-360	Comprehensive Outpatient Rehabilitation Facility Survey Report
HCFA-378	Ambulatory Surgical Center Survey Report
HCFA-449	Hospice Survey Report
HCFA-1537	Hospital Survey Report
HCFA-1537A	Psychiatric Hospital Survey Report
HCFA-1537B	Tuberculosis Hospital Survey Report
HCFA-1538	Hospital Utilization Survey Report
HCFA-1557	Clinical Laboratory Survey Report
HCFA-1569	Skilled Nursing Facility Survey Report
HCFA-1572	Home Health Agency Survey Report
HCFA-1882	Portable X-Ray Survey Report
HCFA-1893	Outpatient Physical Therapy-Speech Pathology Survey Report
HCFA-2786	Fire Safety Code Survey Report
HCFA-3042	Physical Therapist in Independent Practice Survey Report
HCFA-3070	General Intermediate Care Facility Survey Report
HCFA-3070A	Survey for Institutions for Mentally Retarded or Persons with Related Conditions
HCFA-3070B	1977 Standards for ICF Services for Mentally Retarded or Persons with other Related Conditions
HCFA-3070C	Addendum - Institution for Mentally Retarded or Persons with Related Conditions
HCFA-3070D	Addendum - General Intermediate Care Facility Survey Report
HCFA-3427	End-Stage Renal Disease Survey Report

Miscellaneous

HCFA-1513	Ownership and Control Interest Disclosure Statement

Requests to Establish Eligibility

HCFA-29	Rural Health Clinic Request to Establish Eligibility
HCFA-262	Physical Therapist in Independent Practice Request to Establish Eligibility
HCFA-359	Comprehensive Outpatient Rehabilitation Facility Request to Establish Eligibility
HCFA-377	Ambulatory Surgical Center Request For

CERTIFICATION FORMS INDEX

Form Number	Survey Report Form
	Certification
HCFA-417	Hospice Request For Eligibility
HCFA-1514	Hospital Request to Establish Eligibility
HCFA-1515	Home Health Agency Request to Establish Eligibility
HCFA-1516	Long Term Care Facility Request to Establish Eligibility
HCFA-1557	Clinical Laboratory Cover Sheet
HCFA-1856	Request to Establish Eligibility to Provide Outpatient Physical Therapy and/or Speech Pathology Services
HCFA-1880	Request for Approval as Supplier of Portable X-Ray Services
HCFA-3402	End-Stage Renal Disease Facility Request to Establish Eligibility
	Certification and Transmittal
HCFA-1539	Certification and Transmittal
HCFA-1539A	Certification and Transmittal--Spell of Illness(j)(1) Supplement
HCFA-1540	Certification, Transmittal and Determination (ESRD only)
	Deficiency Reports
HCFA-2567	Statement of Deficiencies/Plan of Correction
HCFA-2567A	Continuation Sheet
HCFA-2567B	Post-Certification Revisit Report
HCFA-2567E	Summary of Deficiencies Not Corrected

SYSTEMS REVIEW QUESTIONNAIRE

A. Systems Requirement - relates to the need, objectives, and impact of the system

1. What is the basis for the need of the system (legislation, Executive Order, etc.)? Cite authority.

   Title XVIII of the Social Security Act - Health Insurance for the Aged P.L. 89-97 July 30, 1965, requires the development and implementation of health quality and safety standards and the evaluation of conditions under which providers and suppliers of health services can participate in Medicare and Medicaid. HCFA is subsequently charged with monitoring and validating the process for certifying that providers and suppliers are in compliance with established conditions and standards.

2. Describe the objectives of the system and how they relate to the programmatic/administrative functions of the organization.

   MMACS was designed to reduce the amount of RO staff time required (manual review of current/prior survey findings) to complete the certification or recertification of health care providers and suppliers; and to establish a centralized data source which would provide information on the quality, quantity, and availability of health care related services in the United States.

Through the use of HMACS, we have been able to:

- expedite the SA survey documentation review process in the RO, by providing computer generated current/prior deficiency comparisons (Individual Facility Profiles);
- provide for scheduling/completion of required surveys in accordance with disclosure of information requirements;
- provide for the efficient/economical assessment of RO - Regional Office Program Evaluation System (ROPES) and State survey agencies - State Agency Evaluation Program (SAEP) certification operations;
- maintain uniformity in the certification decision process;
- prepare OSC management reports to advise ROs and SAs of weaknesses or bottlenecks in their operations;
- identify certification problems which require additional training, modification of operating practices or revision of regulations;
- provide information to the Office of the Secretary, Congress, and numerous other sources, on certification information;

- provide facility characteristics for statistical reports and analyses by the Office of Research and Demonstrations, and (most recently) apply screening criteria for determing the frequency of provider surveys, necessitated by reductions in SA budgets.

3 How well is the system meeting objectives? Explain in terms of impact such as, improve timeliness of data, validity of data, usability of data, or results in better decision making, staffing, planning, etc.

System is satisfactorily meeting its objectives. Additionally, all of the deliverables outlined in 2. above were not possible at all, or without prohibitive amounts of staff time, before MMACS.

B. Systems Administration - applies to system development, personnel resources, and planning

1. Is the system currently being supported by in-house personnel, equipment, or by another HCFA component, and/or a private contractor? Indicate by entity and type of support provided.

   - Data Management Branch, Office of Standards and Certification, Health Standards and Quality Bureau - DMB-OSC-HSQB

NUMBER	TITLE	GRADE	% OF TIME
1	Branch Chief	GS-14	100%
2	Program Analysts	GS-13	100%
4	Program Analysts	GS-12	100%
1	Secretary-Typist	GS-05	100%

   - Provider Certification and Data Management Branch, Office of Health Program Systems, Bureau of Data Management and Strategy - PCDMB-OHPS-BDMS.

NUMBER	TITLE	GRADE	% OF TIME
1	Computer Systems Analyst	GS-13	100%
1	Computer Systems Analyst	GS-13	85%
6	Computer Specialists	GS-12	100%
1	Computer Specialists	GS-12	90%
1	Computer Assistant	GS-06	80%

2. Are the personnel resources provided appropriate to support this system? If not, explain.

Yes

3. Are any modifications, changes, or alternatives to the system expected to be implemented during the next 3 years? Include equipment enhancements, increased workloads, new applications, and/or system retirement proposals.

Yes. If a State agency requests approval to do direct input and has the necessary staffing/hardware resources, we will grant approval on an ad hoc basis.

4. Have the above plans been reported to BDMS/OIRM in accordance with HCFA ADP Planning and Budget requirementw to insure that plans are in consonance with budget requests?

Yes

5. Describe the mechanism used for reporting and correcting system deficiencies or irregularities which are recognized by the system user, system operations personnel, etc.

Request for ADP SErvices, "Form SSA-3893, along with specifications memorandum. Use of form is outlined in BDMS procedural description of MMACS HH01-01. And also through telephone contact, formal memorandum, and/or meetings.

6. Was the system development in-house, by another component within HCFA, under contract, or by a combination thereof?

   N/A

7. Complete Exhibit A, Item IV, of this System Review/Recertification Packet.

EXHIBIT A(cont'd)
ITEM IV

Budget Titles and Program Activities

(Circle the appropriate budget code(s) that are applicable to your system.)

Title and Program Categories		Budget Code
1.	HCFA - Program Management Activities	
A.	PSRO	051101
B.	Research-Demonstration & Evaluation Project	051102
C.	Medicare Contractor	051103
D.	State Certification	051104
E.	ESRD Network	051105
F.	Administration Costs	[✓ 051106]
2.	HCFA - Medicaid Grants to States Activities	
A.	Medicaid Vendor Payments	051201
B.	State & Local Administration	051202
3.	HCFA - Payments to Health Care Trust Fund Activities	
A.	Military Service Credit	058001
B.	Supplemental Medical Insurance	058002
C.	Hospital Insurance for the Uninsured	058003
D.	PSRO	058004
4.	HCFA - Federal Supplementary Medical Insurance Trust Fund Activities	
A.	Benefit Payments	800401
B.	Administration	800402
C.	Experiments & Demonstrations	800403
5.	HCFA - Federal Hospital Trust Fund Activities	
A.	Benefit Payments	800501
B.	Administration	800502
C.	Experiments & Demonstrations	800503

C. Equipment - relates to the type of equipment used for the system.

1. List the equipment used in support of this system to include manufacturer, model, and location of equipment.

   REGIONS - Datapoint 6600 Datashare System; ITT Courier terminals (Model #110219-001); and ITT Courier Printers/Controllers (Model #110277-001), located in each of the 10 HCFA Regional Offices. Responsibility for the management of these resources rests with the Regional Administrator in each HCFA Regional Office.

   CENTRAL OFFICE - IBM 4341s (2) and related I/O equipment, support the interactive mode and demand processing. This equipment is controlled/operated by the HCFA Data Center - BDMS.

2. Is the above listed equipment appropriate/adequate to support this system?

   This equipment is adequate to support the system (in a dedicated environment). However, the HCFA Data Center hardware is configured in a multi-user environment, with an ever increasing number of MMACS/Non-MMACS users. At this time, the situation is being monitored, in an effort to determine how additional resources can be allocated to the MMACS activities in order to improve processing turn-around time. It appears that additional upgrades will be needed, unless non-MMACS users can be reallocated. These activities are part of an ongoing ADP planning function centralized in HCFA's Bureau of Data Management and Strategy.

3. If you operate any of the above equipment, are pertinent technical manuals, operation procedures, and standards current and available to all operating personnel? If not, are you taking action to obtain such materials?

All of the related manuals and/or procedures have or are in the process of being revised/distributed.

D. Programming

1. What is the primary programming language used for this system?

   Primary language used is COBOL.

2. What documentation exists that describes each application program used for this system?

   See attached system specification - HH01-01, Section VI, attached.

3. How many programs are there in the system (excluding sorts)?

   See 2. above.

4. Who performs the application programming and related documentation functions in support of this system?

   Office of Health Program Systems (OHPS), Bureau of Data Management and Strategy (BDMS).

5. If programming support and documentation is not adequate, what action is being taken, or would you suggest be taken, to improve the situation?

   Support/documentation is adequate.

6. Are data files reviewed periodically for possible consolidation, data element elimination, and/or standardization? By whom?

Yes. Office of Standards and Certification (OSC) HSQB, and Office of Health Program Systems (OHPS), BDMS.

E. Alternatives

1. Since the system has been declared operational, have any feasible alternative processes (other than those discussed in item B.3) to the current system been identified? Briefly explain each alternative.

   Analyses of the system with regard to proposed modification and/or daily operations have not indicated a better alternate process.

2. Explain what considerations, if any, make the above alternatives inappropriate at this time, e.g., non-availability of experienced personnel, budget constraints, cost factors, compatibility, management decisions, etc.?

   N/A

EXHIBIT A (cont'd)
ITEM II

F. Data Utility - relates to the value you place on the data (both input and output) that the system processes.

1 = Never
2 = Sometimes
3 = Usually
4 = Always

(Circle one for each category)

Responses to each of the following items could be multiple when considered in terms of what is desirable versus what is feasible under current program reporting requirements. For example, submission of data by entities under Periodic Interim Payment (PIP) procedures may not be as timely or current as desired, but may be the best attainable when considered in regard to current policy. Therefore, your responses should be based on what is attainable under current reporting requirements.

You may want to provide a qualifying statement for responses affected by such considerations, if so, please footnote and provide the statement on the reverse side of the page.

1. Is the data believable? (Pertains to your confidence and trust of the data.)

Input 1 2 [✓ 3] 4
Output 1 2 [✓ 3] 4

2. Is the data timely: (Pertains to the data being available when needed.)

Input 1 2 [✓ 3] 4
Output 1 [✓ 2] 3 4

RO [illegible]

3. Is the data sufficiently current? (Pertains to the age and usefulness of data.)

Input 1 2 [✓ 3] 4
Output 1 2 [✓ 3] 4

4. Is the media type (paper, tape, microforms, cards, display terminals, etc.) appropriate for your needs?

Input 1 2 [✓ 3] 4
Output 1 2 [✓ 3] 4

Do you recommend any changes? (Explain)

EXHIBIT A(cont'd)
ITEM II

5. Is the format of the data appropriate?

Input 1 2 [✓ 3] 4
Output 1 ~~[✓ 2]~~ [✓ 3] 4

Do you reformat any of the data after receipt?

Yes ✓ No ______

If yes, explain how and why. [redacted]

Sometimes we prepare charts to summarize data for ease of reference.

6. What percentage of data provided by this system is currently used for decision making and/or user reports (as opposed to "nice-to-know," but not absolutely needed)? Circle one.

10-20 30-40 ~~[✓ 50-60]~~ [✓ 70-80] 90-100

Do you recommend the deletion of any data?

Yes ✓ No ______ See Attached

7. If any data in this system are directly input from a public use report, list the OMB report number(s) below.

NOTE: If data from public use reports are input to this system, but is obtained as an output from another system, do not provide the OMB report number(s).

OMB Report Numbers:

1)	0938 - 0103	Hosp Req for Cert (HCFA-1514)
2)	0938 - 0100	LTC Req for Cert (HCFA-1516)
3)	0938 - 0011	HHA Req for Cert (HCFA-1515)
4)	0938 - 0065	OPT/SP Req for Cert (HCFA-1856)
5)	0938 - 0032	Lab Cover Sheet (HCFA-1557)
6)	0938 - 0027	Portable X-Ray Req for Cert (HCFA-1880)
7)	66-R-0087	ESRD Req for Approval (HCFA-3402)
8)	066-R-0117	RHC Req to Est. Elig. (HCFA-29)
9)	0938 - 0266	ASC Req for Cert (HCFA-377)
10)	0938 - 0313	Hospice Req for Cert (HCFA-417)
11)	0938 - 0267	CORF Req for Cert (HCFA-359)

~~Bill~~

~~[illegible]~~

F.6. ~~[illegible]~~ Carol

Some of the routine MMACS Tables will be replaced by a new series of reports once the OSC deficiency subfile and the MMACS based case control system are fully operational. These new reports will provide the RO and CC management with comprehensive data in all aspects of the survey and certification process

8. Are the data/informationo produced by this system used only by HCFA components or are they provided to other government agencies and/or the public?

NOTE: If the data/information provided by this system is not directly provided to entities outside HCFA, but are instead input to other systems which directly provide such data/information outside HCFA, your response should be "HCFA components only."

G. User

1. List the outputs you receive. Include title, frequency, media type (paper, tape, microfiche, cards, etc.), average number of pages or items per output, number of copies, and uses of each.

Daily -

a) MMACS Table #13 "Individual Facility Profile"
Media - paper
# of pages - 1 1/2" to 4"
# of copies - 1
use - monitor daily RO input

Monthly -

a) MMACS Table #5 "Overdue Recertification Listing"
Media - paper
# of pages - 1" to 3"

# of copies - 1
Use - evaluate S/A ability to process workloads

b) MMACS/POS Table #7033 "Selected Data Listing"

Media - paper

# of pages - 10"

# of copies - 1

Use - reference resource for provider characteristics

Quarterly -

a) MMACS Table #12 "Average Certification Work Processing Times"

Media - paper

# of pages - 2" to 4"

# of copies - 1

Use - identify problems/bottlenecks in certification work flow.

b) MMACS Table #8 "Comparison of State, Regional, and National Deficiency Patterns"

Media - paper

# of pages - 10" to 12"

# of copies - 1

Use - identify high deficiency areas

c) MMACS Table #10 "Frequency of Deficiencies Comparison of State to Nation

Media - paper

# of pages - 10" to 12"

# of copies - 1

Use - identify weaknesses in S/A survey operations

d) MMACS Table #6/6A "Validation Listing - Provider Number Sequence" and "Alphabetical Listing of all Providers"

Media - paper

# of pages - 8"

# of copies - 1 each

Use - reference resource on all providers/suppliers

2. If this system were abandoned or discontinued, what effect would this have on your operation? None, Minimum, Moderate, Significant? Would you need to devise another method for obtaining or disseminating the data?

Significant - yes

3. As the user, are you satisfied with system performance, e.g., timelinessof data, quality of data, presentation, utility of data? If not, identify areas of concern.

Data input support for some ROs is less than totally desirable. Discussion of this problem with the Regional Office Users Group Coordinator indicates it is caused by personnel turnover and current hiring restrictions.

Overall, the operation of the system is satisfactory.

4. Do you maintain a manual system as a supplement to the automated system? If so, explain.

No.

5. Have you been provided with formal written documentation (User's Guide) that explains how to use the system, editing rules in effect explanations, of files, data fields, etc.)?

Yes. See HH01-01, Overall Systems Concept (attached) and the MMACS Brochure at Tab B. Also, screen prompts are in place in each region to guide data entry operators and edit input.

H. Budget - applies to finance related recordkeeping practices, identification and cost contracts, and certification of bills.

1. What finance related records are maintained to support budgetary justification and/or cost benefits analyses?

   a. personnel and related costs are maintained by each organization (HCFA-HSQB, OHPS, regions; HCFA Data Center) involved with the system.

   b. Equipment and communications costs are maintained by BDMS and the Regional ADP Coordinator in each region. For example, BDMS, as part of the HCFAADP budget, provides for all Datapoint/ITT Courier equipment; the regions maintain cost expenditure data for communication with Central Office.

   c. HCFA's Data Center maintains batch and demand processing costs as they pertain to IBM 4341 operations.

   All of the above information is reported to BDMS which incorporates it as part of the HCFA ADP budget and spending plans and for updating the system inventory data base.

2. Who maintains the above information?

   Bureau of Data Management and Strategy (BDMS) and Regional Offices

3. List all applicable contracts by vendor and intra, inter-agency agreements currently in use in support of this program. Include total cost for each, and effective dates, beginning and ending.

Intra-agency - Office of Health Program Systems provides programming and system analyses. Costs total about $270,000.

- Bureau of Data Management and Stragegy (BDMS) provides computer operations support through HCFA Data Center. Costs total about ? (Cost accounting system, which is now under development, cannot currently isolate these costs.)

I. Systems Operation - examines related components and system interfaces to include operations methodology, ADP workloads, recurring requirements, and procedures.

1. Briefly describe the overall operation of the system to include interfaces with other systems and components. This explanation should basically follow the system flow chart as requested in Exhibit B of this AIS Guide.

   Attached (Attachment #I) is the system specification which briefly describes the overall operation of the system.

2. Describe the application methodology (e.g., interactive, batch, query, mixed-mode) and why this approach is best suited in the meeting of objectives.

   See E.1 above.

3. What types of data entry methods are used for introducing data to the system?

   ITT Courier (Model #110219-001) terminals tied to the HCFA Data Center IBM 4341's support daily interaction mode transmissions.

4. How often are computer processes that are directly related to this system executed? Reflect the frequency and number of approximate hours of executive (e.g., twice a week - 3 hours, daily - 5 hours, etc.)

* These figures are qualified estimates.

Frequency	Elapsed Time	CPU Time
Daily	200 min.	25 min.
Bi-weekly	15 min.	5 min.
Monthly	270 min.	125 min.
Quarterly	300 min.	185 min.

5. Describe the procedures/policies that are in effect governing tape and/or disk backup activities (e.g., master files, operating software, libraries, backed-up daily).

Refer to Section IV of HH01-01, Overall Systems Concept, attached.

J. Data File Documentation

Master File ________ Data Base _________

-File Name: MMACS - OC00.PCDMB.HH200401

-Description: Record of current facility characteristics, and all health and/or life safety deficiencies for all providers and suppliers

-Source Document(s): See attachment at Tab A.

-Input Volume: 36,000 records annually

-File Volume: 42,000 records

-Contents: See description above and HH01-01, Overall Systems Concept.

-Update/Retention: Updated daily, retained on history file for 5 years

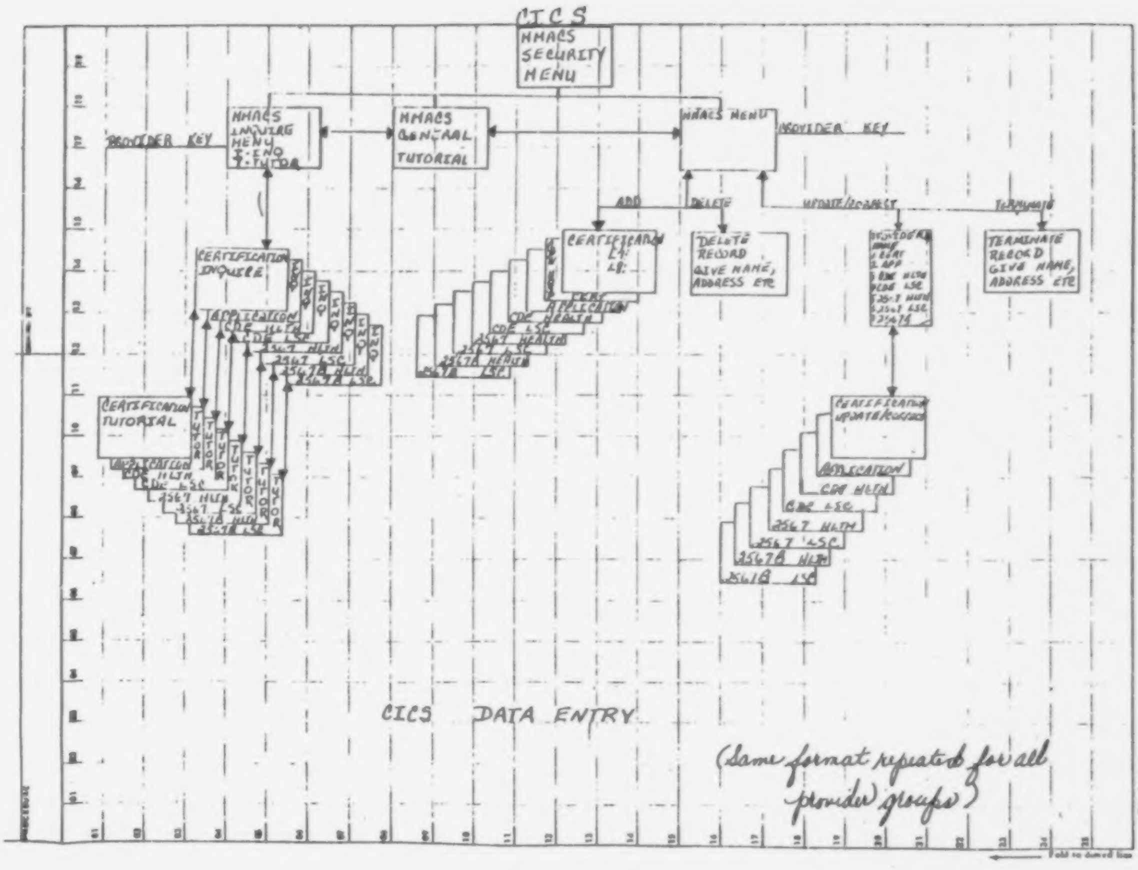
-Uses: See attachment at Tab B.

-File Structure: VSAM

-File Responsibility: OHPS-BDMS

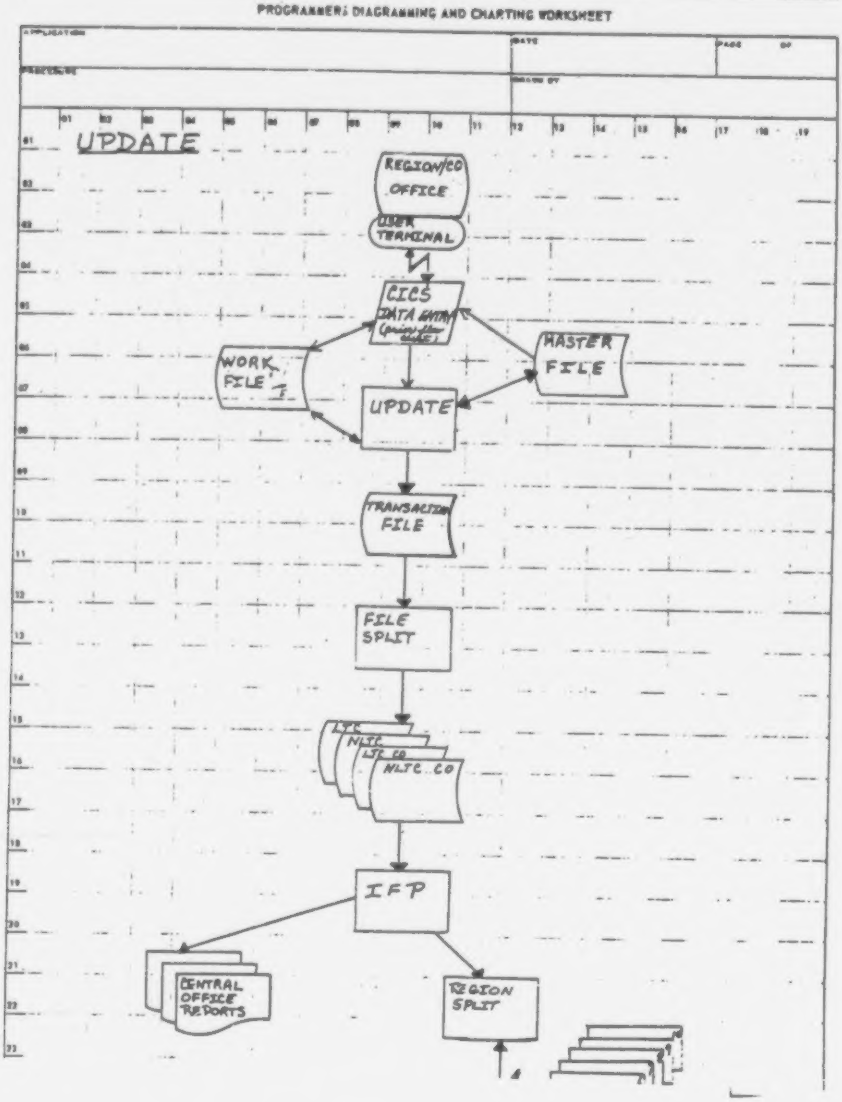
-Storage Device: UNIVAC 1108 IBM 4341's

-Planned Changes: None at this time.


CICS
HMACS SECURITY MENU
PROVIDER KEY
HMACS INQUIRE MENU I-INQ T-TUTOR
HMACS GENERAL TUTORIAL
HMACS MENU
PROVIDER KEY
ADD
DELETE
UPDATE/CORRECT
TERMINATE
CERTIFICATION INQUIRE
APPLICATION
CDE HLTH
CDE LSC
2567 HLTH
2567 LSC
2567A HLTH
2567A LSC
INQ
CERTIFICATION TUTORIAL
TUTOR
CERTIFICATION L1: L8:
CERT
APPLICATION
CDE HEALTH
CDE LSC
2567 HEALTH
2567 LSC
2567A HEALTH
2567A LSC
DELETE RECORD GIVE NAME, ADDRESS ETC
TERMINATE RECORD GIVE NAME, ADDRESS ETC
CERTIFICATION UPDATE/CORRECT
APPLICATION
CDE HLTH
CDE LSC
2567 HLTH
2567 LSC
2567A HLTH
2567B LSC
CICS DATA ENTRY

(Same format repeated for all provider groups)

PROGRAMMERS DIAGRAMMING AND CHARTING WORKSHEET

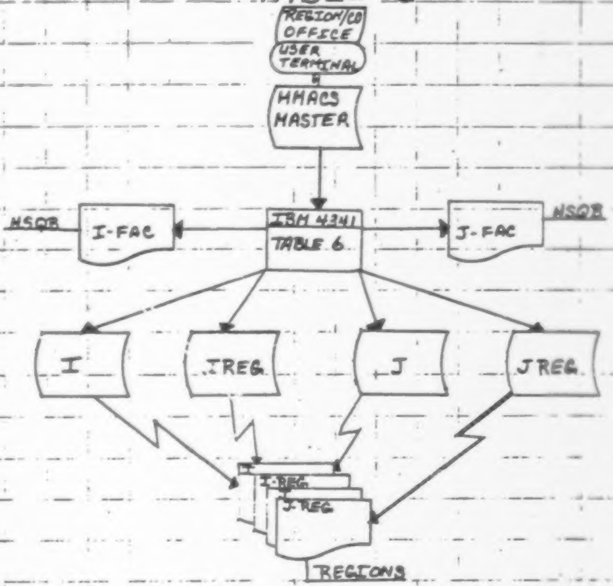

APPLICATION
DATE
PAGE OF
PROCEDURE
DRAWN BY
UPDATE
REGION/CO OFFICE
USER TERMINAL
CICS DATA ENTRY
MASTER FILE
WORK FILE
UPDATE
TRANSACTION FILE
FILE SPLIT
LTC
NLTC
LTC CO
NLTC CO
IFP
CENTRAL OFFICE REPORTS
REGION SPLIT

PROGRAMMERS DIAGRAMMING AND CHARTING WORKSHEET

APPLICATION	DATE	PAGE OF
PROCEDURE	CHARTED BY	

CHRONOLOGICAL LISTING OF TIME-LIMITED AGREEMENT DATES, AUTOMATIC CANCELLATION DATES, ANNUAL SURVEY CYCLE DATES, AND DEFERRED RECERTIFICATION DATES

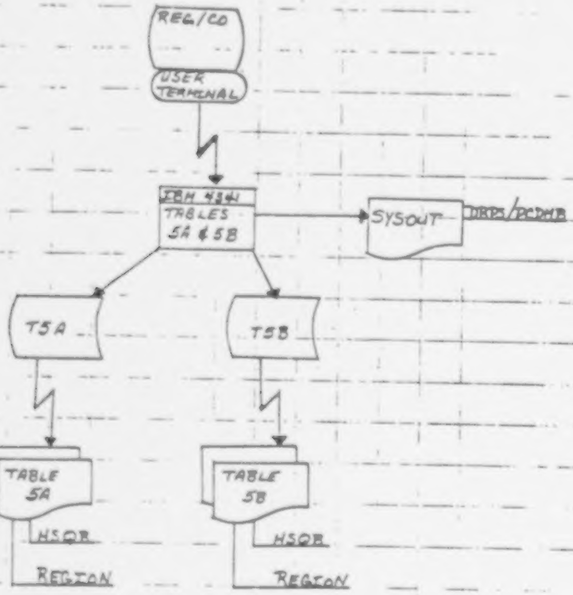
TABLE 6


REGION/CO OFFICE
USER TERMINAL
HMACS MASTER
HSOB
I-FAC
IBM 4341 TABLE 6
J-FAC
HSOB
I
I REG.
J
J REG.
I
I-REG.
J
J-REG.
REGIONS

PROGRAMMERS DIAGRAMMING AND CHARTING WORKSHEET

APPLICATION	DATE	PAGE OF
PROCEDURE	DRAWN BY	

TABLES 5A AND 5B

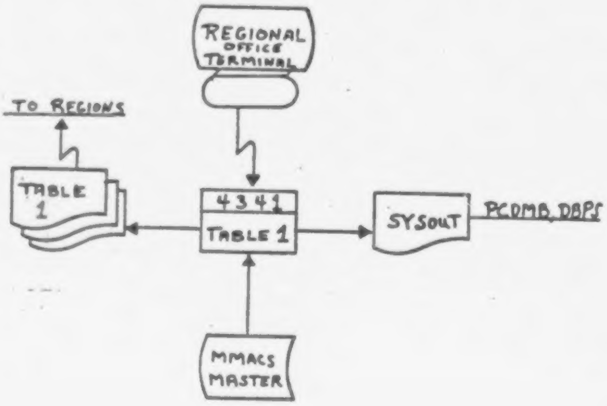

REG/CO
USER TERMINAL
IBM 4341
TABLES 5A & 5B
SYSOUT
DBPS/PCDMB
T5A
T5B
TABLE 5A
TABLE 5B
HSQB
REGION
HSQB
REGION

PROGRAMMERS DIAGRAMMING AND CHARTING WORKSHEET

APPLICATION
DATE
PAGE OF
PROCEDURE
DRAWN BY

TABLE 1

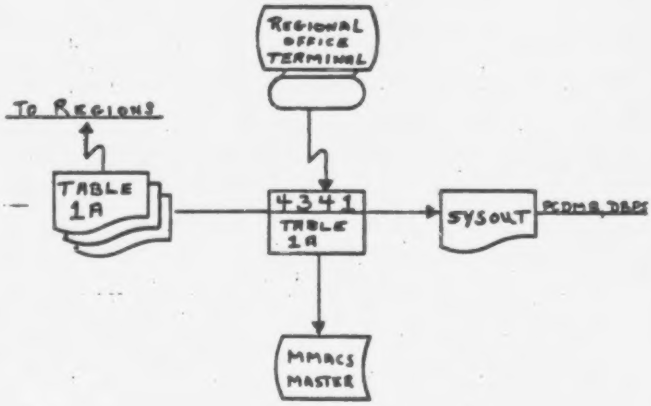
PROVIDER RECERTIFICATION SCHEDULING LISTING


REGIONAL OFFICE TERMINAL
TO REGIONS
TABLE 1
4341
TABLE 1
SYSOUT
PCDMB, DBPS
MMACS MASTER

PROGRAMMERS DIAGRAMMING AND CHARTING WORKSHEET

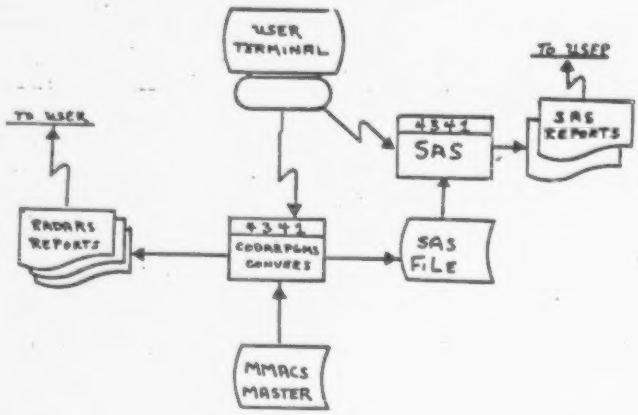
APPLICATION	DATE	PAGE OF
PROCEDURE	DRAWN BY	

TABLE 1A
PROVIDER DEFICIENCY HISTORY LISTING


REGIONAL OFFICE TERMINAL
TO REGIONS
TABLE 1A
4341
TABLE 1A
SYSOUT
PCDMS DBPS
MMACS MASTER

PROGRAMMERS DIAGRAMMING AND CHARTING WORKSHEET

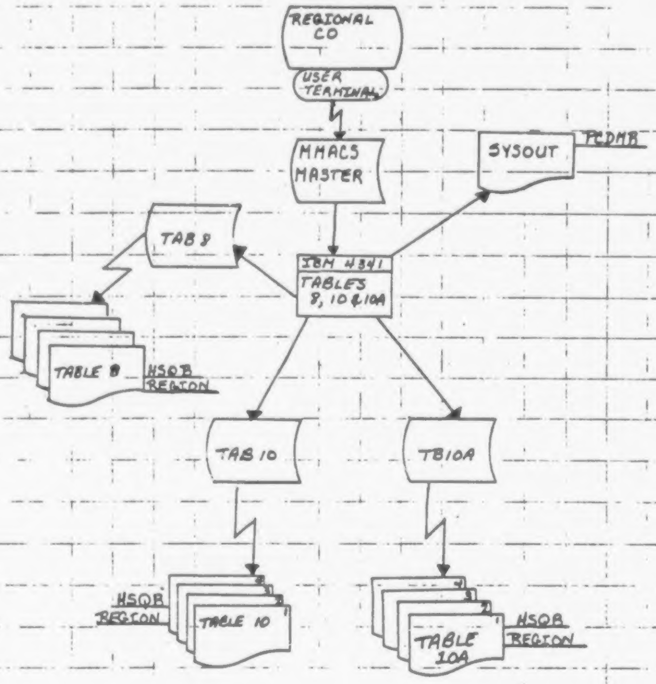
MANAGEMENT INFORMATION REPORT GENERATOR


USER TERMINAL
TO USER
TO USER
4341
SAS
SAS REPORTS
RADARS REPORTS
4341
CODARPGMS CONVERS
SAS FILE
MMACS MASTER

PROGRAMMERS DIAGRAMMING AND CHARTING WORKSHEET

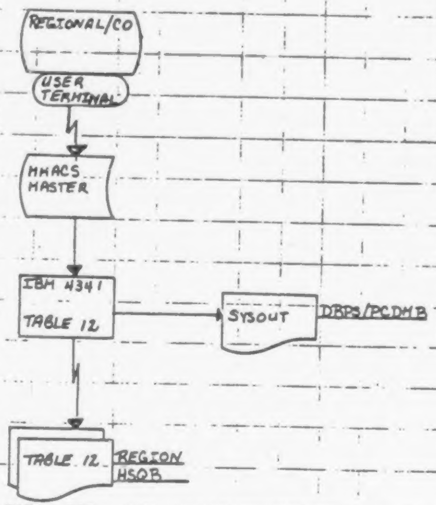
APPLICATION	DATE	PAGE OF
PROCEDURE	DRAWN BY	

TABLES 8, 10 AND 10A


REGIONAL CO
USER TERMINAL
MMACS MASTER
SYSOUT
PCDMB
TAB 8
IBM 4341
TABLES 8, 10 & 10A
TABLE 8
HSOB REGION
TAB 10
TB10A
HSOB REGION
TABLE 10
TABLE 10A
HSOB REGION

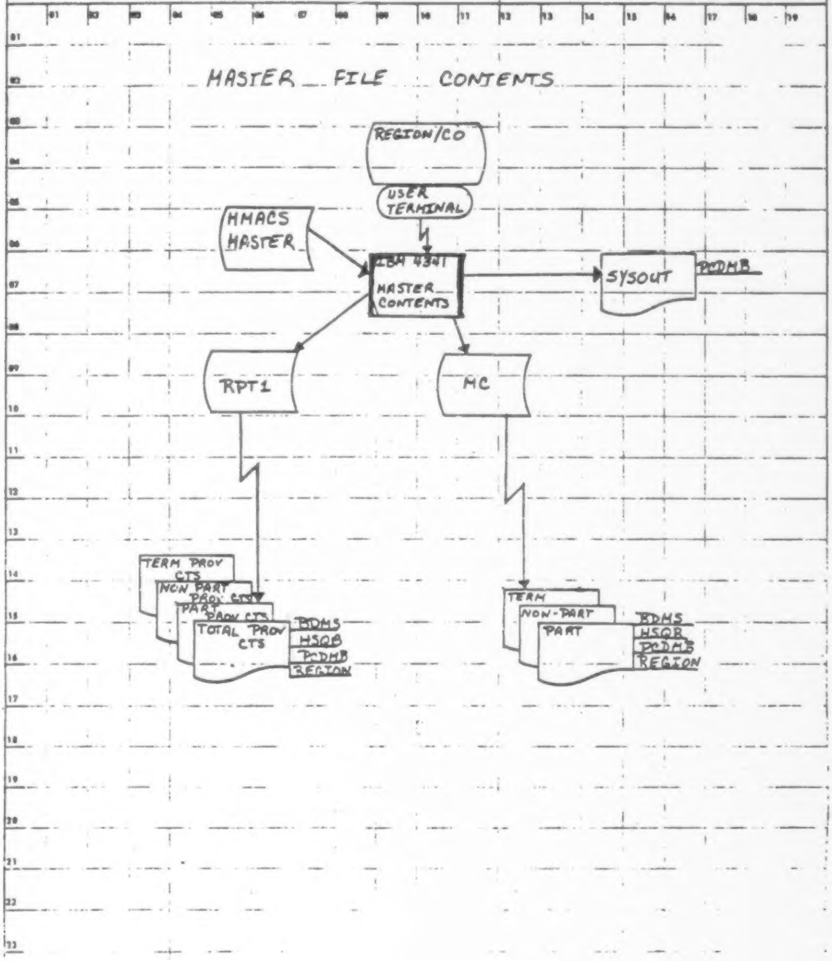
PROGRAMMERS DIAGRAMMING AND CHARTING WORKSHEET

AVERAGE CERTIFICATION WORK PROCESSING TIMES
TABLE 12


REGIONAL/CO
USER TERMINAL
MMACS MASTER
IBM 4341
TABLE 12
SYSOUT
DBPS/PCDMB
TABLE 12
REGION
HSQB

PROGRAMMERS DIAGRAMMING AND CHARTING WORKSHEET

APPLICATION	DATE	PAGE OF
PROCEDURE	DRAWN BY	


MASTER FILE CONTENTS
REGION/CO
USER TERMINAL
HMACS MASTER
IBM 4341
MASTER CONTENTS
SYSOUT
PCDMB
RPT1
MC
TERM PROV CTS
NON PART PROV CTS
PART PROV CTS
TOTAL PROV CTS
BDMS
HSQB
PCDMB
REGION
TERM
NON-PART
PART
BDMS
HSQB
PCDMB
REGION

PROGRAMMERS DIAGRAMMING AND CHARTING WORKSHEET

APPLICATION

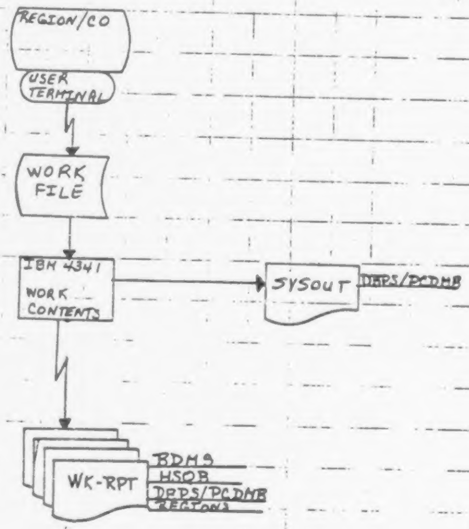
DATE

PAGE OF

PROCEDURE

DRAWN BY

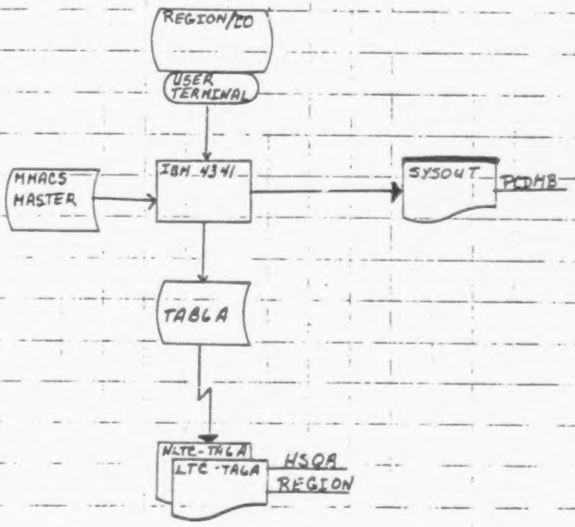
WORK FILE CONTENTS LISTING


REGION/CO
USER TERMINAL
WORK FILE
IBM 4341
WORK CONTENTS
SYSOUT
DPPS/PCDMB
WK-RPT
BDMS
HSOB
DPPS/PCDMB
REGIONS

PROGRAMMERS DIAGRAMMING AND CHARTING WORKSHEET

APPLICATION	DATE	PAGE OF
PROCEDURE	DRAWN BY	

TABLE 6A


REGION/CO
USER TERMINAL
MMACS MASTER
IBM 4341
SYSOUT
PCDMB
TAB6A
NLTC-TAG A
LTC-TAGA
HSQA
REGION

DEPARTMENT OF HEALTH & HUMAN SERVICES REGION III

Memorandum

Date MAR 2 1 1985

From Jim Maiorano

Subject Reply from Region V - National Review of Survey and Certification Activities

To Regional Inspector General for Audit

We received a reply from Region V on March 6, 1985 responding to our request of November 13, 1984 on the above subject. This reply was responsive to the memorandum, and comes to some interesting conclusions.

Highlights of their findings and my comments and recommendations follow.

Facilities Not Surveyed In Last 18 Months

They sampled 100 of the 303 SNFs reported not surveyed in last 18 months and found that two states, Indiana (27 of 29) and Wisconsin (4 of 14) did in fact not survey some of the facilities included in our listing.

Indiana

Region V is preparing a draft report questioning $41.3 millin in Federal funds paid to these homes. A copy of their PAM is attached.

Wisconsin

They sampled 14 of the 74 homes included in our listing and found that 4 (29%) were not surveyed. If the pattern is consistent we could expect 22 SNFs of 384 in Wisconsin to not have been surveyed within 18 months.

Within Indiana and Wisconsin, as well as the other states in Region V they identified other reasons for the apparent "no survey" including:

... HCFA's long delay in entering data into MMACS system

... facilities closing or changing category with no note by HCFA

... change in provider number

... survey not the responsibility of State Agency (these are Christian Science facilities)

They were able to identify that HCFA was "hiding" problem survey results by not putting them on MMACS until deficiencies were corrected. Interestingly this practice was changed on October 24, 1984 just when the U.S. Senate Committee complained to HCFA about delays in implementing "Alternative to Decertification".

Most importantly, however, Region V has concluded that the problem of not surveying or not properly recording surveys has not uncovered a pattern of poor quality of homes.

Partial Surveys (Wisconsin Only)

HCFA "approved" Wisconsin's use of partial surveys, because of money problems. The "partial" surveys ended in August 1983. Wisconsin officials believe that "partial" surveys were unsuccessful and the overall condition of nursing homes may have worsened. They believe that annual surveys are more appropriate.

Conclusions and Recommendations

In accordance with our later instruction they have stopped work on this aspect to devote full time to the second phase - facilities not certified timely. We know that there is a significant problem in Indiana. They will report by March 29, 1985 on the remainder of the states.

My opinion of their reply is that it is responsive, but not really conclusive. As I pointed out to them when we met, our approach was a beginning not all inclusive, and that if certain things were noted they would have to make some determinations of what should be done to determine if there was a real problem. I believe they left too much unanswered. It seems to me that there are some interesting possibilities in both Indiana and Wisconsin to relate lack of surveys with poor quality of care, and most importantly in Illinois problem homes could be a major problem since Region V identified that HCFA "delayed entering survey information on the MMACS until deficiencies identified on the surveys were corrected".

Given our second request and what I experienced during my visit I recommend that we ask for no further work, at least until we get their second reply, and replies from the other Regions.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit
Region IX

Memorandum

Date MAR 28 1985

From OIG Office of Audit

Subject Expansion of National Review on Survey and Certification Activities at Skilled and Intermediate Nursing Facilities

To G. A. Rafalko
Regional Inspector General
for Audit
Office of Inspector General
Office of Audit
Gateway Building
3535 Market Street, Room 10250
Philadelphia, PA 19104

This memorandum presents the results of our review on the timeliness of surveys and certifications of Medicaid skilled and intermediate care facilities in California. We have reviewed the facilities on the Rapid Data Retrieval System (RADARS) listing that you provided us for California. The listing indicated that 141 facilities had not had a survey in the last 14 months. Our review showed that the RADARS listing was not current because HCFA was not updating the information on completed surveys in a timely manner. Our review of individual provider files at HCFA disclosed that for 131 of the facilities the surveys were done within 14 months, for 7 facilities a 60-day extension was granted, and the remaining 3 facilities had been closed.

We are working on the Oregon cases and will send you the results in a separate letter. If you have any questions, please contact Dan McNulty or Ron Yee at 556-7004.

HERBERT WITT
Regional Inspector General
for Audit

RECEIVED
MAR 29 1985

DEPARTMENT OF HEALTH & HUMAN SERVICES

Memorandum

Date March 28, 1985

From Regional Inspector General for Audit
Region V

Subject Survey of Intermediate Nursing Facilities (ACN 05-50153)

To Regional Inspector General for Audit
Region III

In accordance with your request dated February 28,1985, we have performed an audit of the timeliness of surveys in three states (Illinois, Michigan and Ohio). The stated objective of the audit, per the audit guide, was "to identify the amount of Federal funds erroneously reimbursed to nursing homes participating exclusively in the Medicaid program that have not been surveyed within a 14 month period." Our audits disclosed that, except for a few State operated ICF/MR facilities in Illinois, the surveys were timely.

The audit guide identified 650 nursing homes in the three states that, according to the MMACS, were not surveyed within the last 15 months. We randomly selected for review the states' survey files of 165 of these homes. Our review disclosed that the surveys were timely. The results by state were as follows:

State	Per MMACS Total Surveys Identified as Late	Sample Results Total Sampled	Sample Results Total Late
Il.	184*	50	0
Mich.	250	55	0
Ohio	216	60	3**
	650	165	3

*The 184 nursing homes included 12 State-operated ICF/MR facilities which were excluded from our sample selection. The survey results for these 12 facilities had been included in an audit of the overall certification process over State operated ICF/MR facilities (ACN 05-50219). It is expected that the report for that audit, which is being drafted, will have about $6 million (Federal share) in questioned costs claimed during periods surveys were late in seven facilities.

** These three late surveys were only one month late.

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Based on our review of the sample, we are able to conclude that the absence of current survey information on the MMACS was not due to the surveys not being performed in a timely manner. Rather, it was due to HCFA not inputting the survey results on their MMACS in a timely manner.

The above audit results were discussed with Jim Maiorano of your office by Fred Halbig, my Audit Manager for Medicaid audits, on March 20, 1985. Both agreed that there was no need (i) to pursue the remaining nursing homes identified in your memorandum or (ii) to do the additional work called for in the audit guide.

Should you need additional information please contact Fred Halbig at FTS 955-4082.

Asher Tenner

cc: Halbig
Kollmeyer
Simmons
Pervisky

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit
REGION IV
101 MARIETTA TOWER, SUITE 1421
ATLANTA, GEORGIA 30323

Memorandum

Date MAR 28 1985

From Regional Inspector General
for Audit, Region IV

Subject Report on the Timeliness of Nursing Home Certification Surveys in Florida and South Carolina (ACN 04-50152)

To Regional Inspector General
for Audit, Region III

In accordance with your February 18, 1985, request, we have reviewed the timeliness of nursing home certification surveys for the 56 Florida and 41 South Carolina intermediate care facilities and intermediate care facilities for the mentally retarded.

The primary objective of this review was to identify the amount of Federal funds erroneously reimbursed to nursing homes participating exclusively in the Medicaid program that had not been surveyed within a 14 month period; the review was limited to the last two survey periods. The review was performed at the HCFA-HSQ Regional Office and at the Bureau of Health Licensing and Certification in Columbia, South Carolina. Our review consisted of obtaining updated survey data input into MMACS after December 31, 1984, reviewing individual provider certification files, and discussions with HCFA-HSQ personnel.

The review was performed in accordance with the applicable "Standards for Audit of Governmental Organizations, Programs, Activities, and Functions" as considered necessary under the circumstances. The field work was performed between March 5 and March 22, 1985.

Our review showed all 97 (56 in Florida and 41 in South Carolina) facilities had been either surveyed within the past 14 months or terminated from the Medicaid program. Accordingly, no erroneous Medicaid payment occurred as a result of late certification surveys. The current survey data on 64 (34 in Florida and 30 in South Carolina) facilities had been input into MMACS between January 1 and March 4, 1985. Survey data on 28 (18 in Florida and 10 in South Carolina) facilities was in the HCFA-HSQ Regional Office but due to an oversite the data had not been input to MMACS; and survey data on 2 (1 in Florida and 1 in South Carolina) facilities had not been forwarded to HCFA-HSQ by the state survey agency. Three other Florida facilities had been terminated from the Medicaid program. Detailed survey data by facility is attached.

APR

HCFA-HSQ, Region IV, uses MMACS to backup a manual system; the manual system is more current and is more responsive to management needs. The manual system provides a biweekly status report on certification surveys.

Please contact Gary Furlong (FTS 242-2113) for any further assistance.

Emil A. Trezzger, Jr.

Emil A. Trezzger, Jr.

Attachment

Page 1 of 2

FLORIDA
REGION III LISTING

Number	Facility	Survey	Results of Review			
			Survey	Prior	3rd	4th
		10-19-83	10-29-84*	10-19-83	10-29-82	10-14-81
		09-09-83	09-14-84	09-09-83	08-04-82	08-28-81
		10-13-83	10-13-84*	10-13-83	10-29-82	10-14-81
		10-04-83	10-17-84*	10-04-83	11-09-82	10-02-81
		10-19-83	10-18-84	10-19-83	10-27-82	10-22-81
		09-28-83	09-12-84	09-28-83	09-30-82	10-23-81
		06-24-83	06-08-84	06-24-83	06-23-82	06-05-81
		09-22-83	09-13-84	09-22-83	08-26-82	08-26-81
		10-20-83	10-20-84*	10-20-83	11-17-82	12-11-81
		08-31-83	09-26-84	08-31-83	10-06-82	06-16-81
		07-15-83	08-09-84	07-15-83	08-25-82	07-30-81
		10-27-83	11-16-84**	10-27-83	11-30-82	12-15-81
		10-07-83	09-06-84*	10-07-83	10-22-82	09-10-81
		08-24-83	08-29-84	08-24-83	08-04-82	07-28-81
		08-09-83	07-26-84	08-09-83	09-14-82	08-05-81
		08-11-83	08-09-84	08-11-83	08-11-82	09-01-81
		09-29-83	09-20-84*	09-29-83	10-27-82	09-25-81
		09-23-83	09-28-84	09-23-83	09-29-82	08-04-81
		10-13-83	10-24-84	10-13-83	10-13-82	09-17-81
		10-27-83	10-18-84	10-27-83	10-28-82	09-02-81
		09-21-83	09-11-84*	09-21-83	10-14-82	09-09-81
		12-02-82	11-15-84	11-03-83	12-02-82	11-18-81
		08-05-83	07-11-84	08-05-83	10-01-82	08-19-81
		09-28-83	09-27-84	09-28-83	09-01-82	10-05-81
		03-17-83	04-26-84	03-17-83	03-17-82	03-20-81
		09-23-83	09-24-84	09-23-83	09-16-82	08-19-81
		10-21-83	10-31-84	10-21-83	10-15-82	10-13-81
		01-05-83	01-10-84	01-05-83	01-25-82	01-12-81
		11-23-83		TERMINATED	01-18-85	
		09-07-83	10-26-84	09-07-83	10-21-82	09-10-81
		09-29-83	09-20-84	09-29-83	08-26-82	08-04-81
		10-19-83	10-19-84*	10-19-83	09-28-82	09-02-81
		10-14-83	10-03-84	10-14-83	10-17-82	09-02-81
		09-12-83	10-31-84	09-12-83	09-17-82	09-03-81
		10-11-83	10-16-84	10-11-83	10-21-82	10-30-81
		08-11-83	08-31-84	08-11-83	10-19-82	09-15-81
		10-13-83	10-10-84	10-13-83	11-04-82	10-20-81
		08-11-83	08-09-84	08-11-83	07-26-82	07-30-81
		10-13-83	10-22-84	10-31-83	10-06-82	06-02-80
		10-26-83	10-24-84	10-26-83	10-28-82	10-26-81
		08-23-83	08-24-84*	08-23-83	----	---

* Current survey data not on MMACS as of 3-4-85.

** Current survey data has not been transmitted by state survey agency.

Florida
Page 2 of 2

Number	Facility	Survey	Results of Review			
			Survey	Prior	3rd	4th
		00-00-00	09-13-84	08-17-83	09-10-82	----
		01-14-83	10-31-84*	11-23-83	01-14-83	----
		08-17-83	09-13-84	08-17-83	09-10-82	----
		09-23-83	10-24-84*	09-23-83	12-08-82	06-16-82
		10-07-83	09-27-84	10-07-83	02-05-83	06-03-82
		07-26-83	06-28-84*	07-26-83	07-30-82	----
		00-00-00		TERMINATED	12-31-81	
		10-14-83	10-11-84*	10-14-83	11-24-82	----
		08-04-82	08-10-84*	08-24-83*	08-04-82	----
		08-06-82	04-14-84*	08-26-83*	08-06-82	- --
		09-22-83	10-18-84*	09-22-83	09-03-82	----
		09-08-82	09-25-84*	08-31-83*	09-08-82	----
		07-09-82		TERMINATED	04-19-83	
		07-21-83	10-31-84*	07-21-83	02-16-83	----
		08-19-83	09-26-84	08-19-83	10-13-82	----

* Current survey data not on MMACS as of 3-4-85.

Page 1 of 2

SOUTH CAROLINA
REGION III LISTING

			Results of Review			
Number	Facility	Survey	Survey	Prior	3rd	4th
		10-19-83	10-24-84	10-19-83	10-27-82	11-12-81
		09-08-83	09-26-84	09-08-83	09-30-82	09-24-81
		10-26-83	12-05-84**	10-26-83	10-08-82	10-21-81
		10-07-83	10-25-84	10-07-83	10-13-82	10-08-81
		09-01-83	09-06-84*	09-01-83	10-01-82	09-10-81
		07-08-83	07-26-84	07-08-83	07-07-82	06-02-81
		10-26-83	10-04-84	10-26-83	10-29-82	10-29-81
		09-30-83	09-28-84	09-30-83	09-10-82	09-17-81
		09-14-83	09-06-84	09-14-83	09-22-82	09-30-81
		09-23-83	09-27-84*	09-23-83	09-30-82	09-30-81
		09-22-83	09-13-84	09-22-83	09-17-92	09-23-81
		10-13-83	10-18-84	10-13-83	10-20-82	10-14-81
		10-21-83	10-10-84	10-21-83	10-15-82	10-15-81
		10-06-83	10-04-84	10-06-83	10-08-82	10-22-81
		09-23-83	09-14-84	09-23-83	09-17-82	09-25-81
		09-21-83	09-12-84	09-21-83	09-17-82	09-23-81
		10-19-83	11-01-84*	10-19-83	10-15-82	11-25-81
		09-01-83	08-15-84*	09-01-83	09-01-82	08-12-81
		09-07-83	09-27-84	09-07-83	09-29-82	09-23-81
		05-05-83	05-31-84	05-05-83	05-28-82	04-02-81
		10-04-83	10-02-84	10-04-83	10-12-82	10-23-81
		10-13-83	10-10-84	10-13-83	10-06-82	10-28-81
		08-03-83	07-24-84	08-03-83	08-18-82	01-26-82

* Current survey data not on MMACS as of 3-4-85.
** Current survey data has not been transmitted by state survey agency.

South Carolina
Page 2 of 2

Number	Facility	Survey	Results of Review			
			Survey	Prior	3rd	4th
		05-20-83	05-18-84	05-20-83	05-25-82	----
		00-00-00	01-18-84*	01-21-83*	----	----
		03-04-83	03-01-84*	03-04-83	----	----
		10-29-82	10-18-84	12-09-83*	10-29-82	01-07-76
		06-10-83	06-28-84	06-10-83	06-16-82	----
		09-09-83	09-21-84*	09-09-83	08-13-82	----
		11-30-82	12-28-84*	12-01-83	11-30-82	----
		12-16-82	11-14-84	12-06-83*	12-16-82	----
		12-16-82	11-15-84	12-07-83*	12-16-82	----
		06-17-83	06-14-84	06-17-83	05-11-82	----
		03-14-83	04-06-84	03-14-83	----	----
		05-27-83	05-24-84	05-27-83	05-05-82	----
		06-22-83	05-08-84	06-22-83	05-06-82	
		02-01-83	03-02-84	02-01-83	----	----
		12-14-82	10-10-84*	12-06-83	12-14-82	----
		12-15-82	11-30-84*	12-29-83	12-15-82	----
		06-15-83	06-27-84	06-15-83	06-15-82	----
		02-22-83	01-10-85*	01-13-84	02-22-83	----

* Current survey data not on MMACS as of 3-4-85.

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Memorandum

Date [APR 4 1985]

From Richard P. Kusserow
Inspector General

Subject Priority Audit Memorandum - Indiana - Certification of Intermediate Care Facilities (ICFs) and Skilled Nursing Facilities (SNFs) Under Medicaid - ACN: 05-50150

To Carolyne K. Davis, Ph.D.
Administrator, Health Care
Financing Administration

This memorandum alerts you to a preliminary significant audit finding disclosed during our review of SNF and ICF survey and certification activities under Indiana's Medicaid program.

Specifically, we identified 261 facilities, out of 352 facilities reviewed, that operated without valid provider agreements during varying periods between June 1, 1982 and September 30, 1984. This was due to the State survey agency not conducting recertification surveys of all facilities participating in Medicaid. Payments to these facilities during the times they were not certified totaled about $67.7 million (Federal share).

In April 1982, claiming a shortage of funds due to the reduction in FFP, the State Medicaid agency requested a waiver of the regulatory requirement to conduct annual surveys of all facilities and to maintain time limited agreements which corresponded with the certification period. HCFA responded with a short-term interim national policy that provided authority for all States to prioritize survey activities as a temporary solution to a funding problem several States reported they were experiencing.

The State agency erroneously interpreted this temporary policy to be the waiver they had requested. Because there actually was a staffing shortage instead of a funding problem, the State survey agency curtailed onsite recertification surveys at all facilities except ICFs. Time limited agreements with all facilities were suspended; prioritized survey activities as suggested by HCFA were not implemented.

With respect to the State Medicaid agency's claim that a funding shortage existed, our review disclosed that the State survey agency did not spend all funds received for recertification surveys in fiscal years 1982, 1983 and 1984. In 1982, for example, 5 providers were not surveyed/recertified to continue participation in Medicaid despite a surplus of $347,160 at the end of the year. In 1983, there were 153 providers not surveyed/recertified despite a surplus of $237,983.

For fiscal year 1984, HCFA regional officials advised the State survey agency that full Federal funding had been restored and it was expected that the necessary staff would be obtained and that full and timely certification activities would be resumed to avert loss of both certification funds and FFP. Nevertheless, 256 SNFs and ICFs had not been surveyed/recertified despite a surplus of $273,564 at the end of the fiscal year.

From correspondence we have reviewed, it is clear that HCFA regional officials were aware, in 1983, of the State survey agency's curtailment of onsite recertification surveys at certain facilities. It is not clear, however, why deferral action by HCFA was not taken earlier because of the State's failure to perform recertification surveys in all facilities.

We know of no waiver that was granted to the Indiana State Medicaid agency to discontinue recertification surveys and time limited agreements. Federal regulations state that FFP is available in expenditures for SNF and ICF services only if the facility has been certified as meeting required conditions for participation. Regulations further require that, the State agency perform onsite inspection of a facility at least once during each certification period; the duration of a provider agreement generally may not exceed 12 months; and the provider agreement must be for the same duration as the certification period set by the State survey agency.

Accordingly, in a draft audit report we will send to the State Medicaid agency in April 1985, we will recommend a financial adjustment totaling about $67.7 million, and that procedures and controls be established to ensure the making of appropriate recertification surveys of all facilities in accordance with Federal regulations.

We understand that the HCFA regional office has deferred $21.2 million claimed by the State agency for the quarter ended December 31, 1984, based on findings being developed by our office. Since HCFA's action indicates concurrence with our finding that many facilities in Indiana remain uncertified and operating without valid provider agreements, we believe you should consider undertaking, as necessary, recertification surveys in such facilities to ensure that no serious violations of Federal standards exist, i.e., deficiencies that immediately jeopardize the health and safety of patients. Further, we believe you should begin initiating the disallowance process for FFP claimed by Indiana for those facilities which are the subject of this memorandum.

We would appreciate receiving, within 30 days, any comments you may wish to offer on these matters.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit
Region II

Memorandum

Date April 5, 1985

From Regional Inspector General
for Audit

To Gervus A. Rafalko
Regional Inspector General
for Audit, Region III

Subject Request for Information on Survey and Certification Activities at Intermediate Nursing Facilities in New York and New Jersey - Audit Control No. 02-50201

This is in response to your memo of February 28, 1985, requesting certain information on survey and certification activities at intermediate nursing facilities in New York and New Jersey. You requested that we obtain information on intermediate nursing facilities that were identified as not being surveyed within the last 15 months as of December 31, 1984. These facilities were identified by accessing HCFA's Medicare/Medicaid Automated Certification System (MMACS) which is the principal management tool available to HCFA for monitoring nursing home compliance with Federal regulations. The objective of our review was to identify: (1) the amount of Federal funds erroneously reimbursed to nursing homes participating exclusively in the Medicaid program that have not been surveyed within a 14-month period and (2) determine whether HCFA is using MMACS as a management tool for monitoring State survey functions.

Background

We found in New York that surveys of Health Related Facilities (HRF's-New York's title for Intermediate Care Facilities) and the Intermediate Care Facilities for Mentally Retarded (ICF/MR) Developmental Centers are performed by the New York State Department of Health (NYS DOH) area offices. Community-based ICF/MR's are surveyed by the New York State Office of Mental Retardation and Developmental Disabilities (NYS OMRDD) area offices. All surveys are sent to NYS DOH in Albany, New York with a recommendation for certification or termination. NYS DOH reviews the surveys and recommendations and, for Medicaid facilities found to be in compliance with Federal regulations, sends the survey package with a Medicare/Medicaid certification and transmittal form to the New York State Department of Social Services (NYS DSS) for signature. For facilities that are not in compliance, NYS DOH sends the survey package and a termination letter to be signed by NYS DSS. NYS DSS completes the certification process by issuing a provider agreement based on the signed Medicare/Medicaid certification and transmittal form.

The Health Care Financing Administration (HCFA) receives the survey package for all facilities from NYS DOH. The signed Medicare/Medicaid certification and transmittal form, provider agreements and termination letters for HRF's and the ICF/MR Development Centers are sent to HCFA by NYS DOH. For the community-based ICF/MR's, the documents are sent by NYS OMRDD HCFA enters the survey information into MMACS when they receive all the survey and certification documentation.

In New Jersey, we found that all surveys are conducted by the New Jersey Department of Health (NJ DOH). For Medicaid facilities NJ DOH sends the survey package to the New Jersey Division of Medical Assistance and Human Services for completion of the Medicare/Medicaid certification and transmittal form and issuance of the provider agreement. This agency is also responsible for issuing termination letters. Once the survey process is complete, a copy of the entire package is mailed to HCFA for review and input into MMACS.

Results of Review

According to the printout obtained from MMACS as of December 31, 1984, there were 150 HRF's and 289 ICF/MR's in New York that were not surveyed within the past 15 months. For New Jersey, the printout showed 202 ICF's and three ICF/MR's out of compliance.

Review at the State Agency

We began our review at State offices in Albany, New York and Trenton, New Jersey. Shown below are the audit steps you requested we perform at the State level, followed by the results of our tests of each area.

Step 1. Determine if nursing homes out of compliance according to HCFA records, were, in fact, out of compliance. In other words, were surveys made within Federal timeframes?

Auditor's Reply: Our review of New York and New Jersey survey records showed that all the facilities listed on the MMAC printout were surveyed and in compliance with Federal timeframes.

Step 2. For those nursing homes out of compliance, identify all Federal funds reimbursed to homes during the periods of noncompliance.

Auditor's Reply: As stated above, all facilities listed on the MMAC printout for New York and New Jersey were in compliance.

Step 3. For those nursing homes that were surveyed within Federal timeframes, determine if the State agency forwarded material to HCFA. On a selected basis, trace a few back to HCFA and determine why there was no input to MMACS.

Auditor's Reply: We found in New York that the survey and certification documentation is sent to HCFA in piecemeal fashion. A copy of the survey package is sent by NYS DOH to HCFA at the same time the package is sent to NYS DSS for completion of the certification process. After NYS DSS signs the Medicare/Medicaid certification transmittal form and issues the provider agreement or issues a termination letter, two copies of each of these documents are sent to NYS DOH for HRF's and ICF/MR's Developmental Centers and two copies to NYS OMRDD for the Community ICF/MR's. It is the responsibility of these agencies to send one copy to HCFA to complete the survey and certification package for input into MMACS.

For the HRF's and the ICF/MR Developmental Centers, we found that NYS DOH was sending all the survey and certification material to HCFA once the process was complete. However, we did find a problem with the community-based ICF/MR's. Of the 289 ICF/MR's listed on the MMACS printout, 220 were community-based and according to HCFA, 112 Medicare/Medicaid certifications and transmittal forms and provider agreements were not received by them. We checked with the State and found that NYS OMRDD did not mail a copy of these documents to HCFA during the period December 1, 1984, through March 1985. NYS OMRDD indicated that there was a change in personnel and that the new employee responsible for mailing the documents was not made aware of this new responsibility. NYS OMRDD was unable to tell us exactly which documents were not mailed. Based on the above, we can only assume that the documents for 112 community-based ICF/MR's were never sent to HCFA.

In addition to the above, we selected ten HRF's and ten ICF/MR's and traced them back to HCFA to determine why there was no input to MMACS. We found that HCFA will not enter information into MMACS if a problem is found during the review of the survey package. Until the problem is corrected, this information will not be entered into MMACS. In addition, survey and certification packages have been received but not entered because of a serious backlog problem that exists due to personnel shortages. HCFA did not maintain statistics showing how many of the backlogged cases were due to problems they had with the survey package. Because of the tight timeframe for completion of this review we did not attempt to identify this number. If you believe it is necessary to do so, please let us know and we will perform follow-up work in this area.

In New Jersey, we found that the survey and certification documents were forwarded properly to HCFA. New Jersey sends all the documentation together in one package to HCFA for review and input into MMACS. What we found in New Jersey was that of the 202 ICF's that were listed on the MMACS printout, 192 are attached to Skilled Nursing Facilities (SNF's). The remaining ten are free standing. The attached ICF beds are classified as swing beds that can be switched back and forth between SNF and ICF depending on the type of patient occupying it. During December 1982, HCFA decided to classify all ICF swing beds as SNF beds to avoid the problem of double counting. Since the survey of a SNF and ICF are done at the same time, the information would be entered into MMACS under the SNF provider number. However, it took HCFA until January 1985 to finally resolve this problem and begin entering ICF survey and certification information into MMACS under the SNF provider number. No input was done during the period December 1982, through January 1985.

We reviewed MMACS data related to 34 facilities and found that HCFA is presently entering ICF current survey and certification information under the SNF provider number. This accounts for the appearance of 192 ICF numbers on the MMACS printout. HCFA is currently removing the 192 ICF provider numbers from the MMAC system.

The remaining ten ICF's are free standing and will remain separate on the MMAC system. These ten ICF's and the three ICF/MR's that were also listed on the MMACS printout should have current survey and certification information. We decided to review the recent survey and certification history of these facilities to determine why information was not entered into MMACS. The same reasons were given by HCFA as those given for New York, i.e., the information was received but not entered because problems were found with the survey or because of backlog problems.

Step 4. If surveys were not made as required, determine why not through interviews. Do State officials interpret Federal regulations differently?

Auditor's Reply: For both New York and New Jersey, the surveys were made within Federal timeframes.

Step 5. Through interviews, determine if the State agency has been contacted by HCFA officials regarding timing of surveys, performance of surveys, etc.

Auditor's Reply: We found that for New York and New Jersey, HCFA is using summary sheets on all facilities, maintained manually, for monitoring the timing and performance of surveys. Both States are in constant communication with HCFA.

Review at HCFA Regional Office

Shown below are the audit steps you requested we perform at the HCFA Regional office followed by the result of our tests of each area:

Step 1. Determine current status of State surveys for all nursing homes included in the MMACS printout. This involved:

a. Updating our listing to determine if survey data was input into MMACS after our cutoff date of December 31, 1984.

b. Checking with HCFA personnel to determine status of nursing homes where no survey information was input after December 31, 1984.

Auditor's Reply:

New York

We updated our listings in New York through March 21, 1985 for HRF's and ICF/MR's and the following is the result of our analysis at the HCFA Regional office:

MMAC 3/21/85 SURVEY DATA

No. Facilities Reviewed		No Date Shown	Year of Latest Survey Shown						
			1979 Date	1980 Date	1981 Date	1982 Date	1983 Date	1984 Date	1985 Date
HRF	150	-	1	2	8	44	65	29	1
ICF/MR	289	25	-	-	1	25	198	40	-
Total	439	25	1	2	9	69	263	69	1
Survey Status of Above Facilities									
Current	108	-	-	-	-	-	38	69	1
Not Current	331	25	1	2	9	69	225	-	-
Total	439	25	1	2	9	69	263	69	1

The above schedule shows that of 439 HRF/ICF/MR's, only 108 reflected current survey and certification information. We found that HCFA updated survey information on 70 facilities that were listed on the December 31, 1984 MMACS printout. (This includes 69 shown under 1984 and one in 1985.) In addition, we found that 38 facilities showing 1983 as the latest survey dates were actually current because the 1984 surveys were conducted late in calendar year 1984 and NYS had not completed the certification process. The remaining 331 facilities (75%) were not current because: 1. NYS OMRDD failed to mail the certification documents to HCFA for 112 facilities, 2. survey and certification information was not entered into MMACS because of a backlog problem caused by personnel problems within HCFA and, 3. HCFA does not enter information if a problem is found during the survey review process. Our analysis found that survey data has never been entered for 25 ICF/MR's. Some of these facilities have been surveyed by NYS since 1980. Our analysis also shows that survey information has not been updated for some facilities since 1979 and 1980.

New Jersey

We updated our listings in New Jersey through March 16, 1985 for ICF's and ICF/MR's and the following is our analysis at the HCFA Regional office in New York:

MMACS 3/16/85 SURVEY DATA

No. Facilities Reviewed		Year of Latest Survey Shown 1978 Date	1979 Date	1980 Date	1981 Date	1982 Date	1983 Date
ICF	202	1	25	121	41	3	11
ICF/MR	3	-	-	-	-	-	3
Total	205	1	25	121	41	3	14
Survey Status of Above Facilities							
Current	-	-	-	-	-	-	-
Not Current	205	1	25	121	41	3	14
Total	205	1	25	121	41	3	14

This schedule shows that HCFA has not updated the New Jersey file between December 31, 1984 and March 16, 1985. All of the facilities listed do not have current survey information. As stated before, 192 of the ICF's are attached to SNF's and the survey information for both facilities is entered under the SNF provider number. HCFA has indicated that the provider numbers for the attached ICF's will be terminated from MMACS. This brings our number down on the MMACS printout to ten ICF's and three ICF/MR's which do not reflect current survey data. Reasons for outdated survey information in New Jersey, provided by HCFA, are the same as those listed for New York State.

Step 2. For those homes that were either updated since December 31, 1984 or have survey reports in the regional office but not on system, determine if 14 month requirement was met for both survey periods.

If the requirement was not met, then further work is required at the State agency to determine if a financial adjustment is warranted.

Auditor's Reply: We determined that for New York and New Jersey, the Federal timeframes were met and no financial adjustment is warranted.

Step 3. Determine through interviews if MMACS is used as a management tool to monitor State survey functions. If not, why not? Check for any policies and procedures on updating MMACS which could affect its use as a management tool.

Auditor's Reply: We have concluded that for New York and New Jersey, the MMACS is not used as a management tool to monitor State survey functions because the information in it does not represent current survey and certification information on all facilities. HCFA relies on a manual system for monitoring these States.

A possible solution to this problem would be to have survey and certification information entered into MMACS at the State level. Direct input at the State level would eliminate mailing delays and the backlog problems experienced at the HCFA Regional office. HCFA staff could review survey packages on an after-the-fact basis.

Step 4. Determine through interviews and record review what actions, including withholding of Federal funds, HCFA has taken to insure that nursing homes are surveyed annually.

Auditor's Reply: New York and New Jersey are in compliance with Federal timeframes so punitive actions, such as withholding Federal funds, would not be warranted.

A verbal report on the results of our review was given to Patrick Marion of your staff on April 3, 1985. We trust this will satisfy your request for information on this subject. If you have any questions or need more data, please call Frank Zuraf of my Albany staff on FTS 562-3971.

John Tournour

Enclosure #1

STATE OF IDAHO
DEPARTMENT OF HEALTH AND WELFARE
FACILITY STANDARDS PROGRAM
420 West Washington Boise ID 83720-9990 (208) 334-4169

MEMORANDUM

DATE: April 8, 1985

TO: Nancy Rothwell, RPT, MPH, Chief
Survey and Certification Review Branch
Division of Health Standards and Quality

FROM: Jean Schoonover, RN, Manager Jean
Facility Standards Program

SUBJECT: Topics for Discussion -- April 25, 1985
State Agency/Regional Office

The most significant and unfortunate change in state and federal relationships over the past five to six years has been the inability for state surveyors and federal surveyors to discuss survey findings, share information, and basically support and nourish each other. We believe the cutbacks in budget for the regional offices, which has reduced staff and travel, has contributed to this detrimental situation. Idaho has experienced productive working relationships with the regional office in the past in which the state and federal surveyors learned from each other. We no longer find that opportunity primarily due to the lack of surveyor-to-surveyor contact. This situation tends to place federal surveyors in a position of "telling" the state agency their findings, which are not always understood or supported by the state agency, instead of sharing ideas which lead at least to a concensus of agreement. This, in turn, creates an atmosphere of animosity between equally professional and knowledgeable employees at both the state and federal levels. Irregardless of the appropriateness of this kind of reaction, the fact remains that the feelings do exist at both the state and federal levels and the building of working relationships suffer. When communications consist in a large part of mutual criticisms and mixed messages, distrust and frustration is a sure result.

It is my sincere hope that you and I can direct our staffs in such a way as to break this pattern that has insidiously developed over the past few years and has continued even with new employees who question some of the regional office actions.

The plan to have a rather informal discussion following the Surveyors' Conference is a positive step forward in my opinion. Surveyors must be able to talk to each other and work out differences. I truly believe there are no differences which cannot be clarified and mutually resolved or at least accepted. The face-to-face discussion is superior to the telephone conference. We look foward to the opportunity. In addition, an excellent learning atmosphere is the joint federal/state survey if more could be arranged.

We have gathered information regarding regional office survey findings or instructions from regional office which have lead to state agency confusion or which differ from the state agency interpretation or understanding. I am enclosing a list of such issues for discussion at our April 25 meeting. Some of the issues may be ones that arose some time ago. Please recognize that some of the past issues have lead to the present misunderstandings and remain unresolved. If we can clarify the questions the state agency has, it should lead to greater understanding between the regional office and the state agency. The issue list is enclosed.

JS/nh

Enclosure

cc: Bee Biggs, RN
Thomas G. Wallner

TOPICS FOR DISCUSSION
STATE AGENCY/REGIONAL OFFICE MEETING
Seattle, Washington
April 25, 1985

1. If the regulations require a certain professional on the facility staff or as a consultant, do we require it only if we see a problem with the corresponding service?

   Example #1: An ICF/MR of less than 15 beds employs a dietitian to oversee the food services. She visits occasionally. No staff member at the facility is designated repsonsible for food service. Living unit staff share the responsibility for food preparation. No one has experience or training in food service or nutrition. Staff turnover is great. The state surveyor cited 442.473(c) as a deficiency. The facility wrote to the regional office for an interpretation. The state surveyor was contacted by the regional office and was informed that the deficiency was not appropriate. The regional office then sent a letter to the facility with recommendations equivalent to the surveyor's deficiency. (See Attachment #1.)

   Example #2: F224 of the SNF survey report form requires that therapeutic diets are planned ". . .with supervision or consultation from the dietitian. . ." There doesn't seem to be any flexibility to this requirement from the state agency's point of view. The surveyor cited F224 as "not met" since there was no dietitian on staff or on contract to the facility. The regional office staff informed the surveyor that the deficiency should not have been written since there were no problems cited in dietary services. (See attachment #2, memo to Loyal Perry from Barry Goff.)

2. Federal deficiencies have been written that the facility charted the percentage of food taken by a patient without identifying what specific foods were eaten. This has been cited without evidence that strict food monitoring was indicated. When would the regional office expect to find this type of monitoring and what documentation should be given to support the citation?

3. What percentage of drugs errors would warrant a deficiency? Does the type of medication affect your decision? Under what conditions would the deficiency be entered as a documentation problem or an administration problem?

4. Does the facility have to document the effect of prn medications in all instances?

5. Federal deficiencies are often written regarding patient rooms; i.e., "Not designed or equipped for adequate nursing care, comfort, and privacy. . ."

Example: Curtains did not enclose beds and beds not two feet apart.

State agency observation: Regulations do not require curtains to enclose beds nor that beds be two feet apart. There were no examples given to indicate that privacy was lost or adequate nursing care wasn't provided. In one particular instance the beds were closer together for a specific comfort and care delivery purpose in the room where several wheelchair patients resided.

Question: Can a citation be made regarding privacy assuming that it isn't available or should lack of privacy be observed? Is the design of a room arbitrary or are the needs of the individual patients in that room considered?

6. A requirement for reality orientation is often cited by the regional office surveyors for all confused patients. Reality orientation is a formal program designed for certain individuals who could benefit from the program. All confused patients may not. What does the regional office look for to determine who needs reality orientation and can it be cited as a deficiency when there is no requirement for reality orientation? Could it be a recommendation instead? Does it need physician approval?

7. There are not temperature requirements for water in the laundry although CDC recommends one of "about 160°" in the absence of other sanitizing procedures. Facilities have been cited by the regional office for improper water temperatures without documentation to support the decision. Does the regional office look for other sanitizing methods such as chemical, dryers, mangles, etc.? This is especially significant in regard to personal laundry citations.

8. Under what circumstances should personal items such as combs, brushes, water carafes, and drinking glasses be identified to the patient? This appears to be a new requirement. Should facilities be notified?

9. "Restrain prn for safety" is a common physician order. What more is expected when the facility has a standing policy for posey restraints?

10. Please discuss your expectations of measurable goals on care plans; depth. Inclusion of acceptable practice statements -- standard care plans.

11. "PT as ordered" is a common physician order and is specific on the PT care plan signed by the physician. Is this acceptable?

12. The Patient Care Plan refers to the patient activity plan for details. Why is this not acceptable?

13. Please discuss substantial compliance at the survey level; i.e., degree of problem before it becomes a deficiency.

    Example: Deficiency cited by the regional office surveyors when three wheelchair patients were observed without slippers or socks. While we agree that it is inapprorpiate, there were 72 other patients appropriately attired.

14. Should evidence that a problem exists be documented on the survey report form to support a deficiency?

    Example: The regional office deficiency "2 cases observed. Where staff fed patients with a syringe without first attempting verbal or sensory stimuli to encourage use of spoon feeding." Shouldn't the survey report form continue with evidence that the patients could respond to stimuli? Did the regional office surveyor check with staff or records to see if patient would respond or that it had been tried and abandoned over a period of time?

15. "Call bells are not in reach of all patients" is frequently cited. Does this apply to ambulatory patients?

16. We see expansion of regulations such as:

    (a) night lights;
    (b) short-term goals on patient care plans;
    (c) prn orders need to be discontinued if not used regularly;
    (d) infection control log;
    (e) prohibition of single bar soap.

17. Please discuss your expectations in regard to requiring "frequent assessments."

18. It appears that the regional office surveyors apply surveyor guidelines as deficiencies. The Basic Surveyor Training Course and legal opinions say that they cannot be enforced. Please elaborate.

19. Are outcomes of care, patterns, and trends the basis of the regional office deficiency decisions opposed to written documents, isolated, or few incidences?

20. The Idaho state agency reviews approximately 60 percent (60%) of all residents. Do you feel that this review should provide the surveyor with a fair and reasonable picture of care at the facility?

JS/nh

cc: Bee Biggs, RN
Thomas G. Wallner

Health Care Financing Administration

6325 Security Boulevard
Baltimore MD 21207

APR 11 1985

RECEIVED
APR 15 1985
FACILITY STANDARDS
PROGRAM

Jean Schoonover, Supervisor
Licensing and Certification
Department of Health and Welfare
Statehouse
Boise, Idaho 83720

Dear Ms. Schoonover:

Last year we proposed a series of modifications to the termination procedures in the State Operations Manual (SOM) and the Regional Office Manual (ROM). The intent of the proposals was to clarify applicable law, regulations, and policies and how we expect them to be applied. In particular, we sought to make the procedures more responsive to immediate and serious threat situations.

In the course of soliciting comments on the proposals, several of the State survey agency Directors expressed concern that the proposed procedures were either illegal or unreasonable. In response to these and other concerns, we postponed issuance to reevaluate the proposals.

Since last November, our Office of General Counsel has determined that the procedures, as drafted, were consistent with applicable law and regulations. Thus, we are satisfied that the procedures are legitimate expressions of program requirements. Nevertheless, we appreciate the need for reasonableness and your acceptance of the proposals as a viable method for balancing the rights of the providers with the rights of beneficiaries and the Federal government.

Enclosed is the latest draft of our proposed termination procedures for your review and comment. I look forward to discussing these proposals with you when we meet in Santa Fe on April 25, 1985.

Sincerely yours,

Sharon Harris

Sharon Harris
Acting Director
Office of Survey and Certification
Health Standards and Quality Bureau

Enclosure

cc:
AHFLCD Officers and Board of Directors

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Audit Agency
Regional Office VI

Memorandum

Date April 18, 1985

From Regional Inspector General for Audit

Subject Status of Nursing Home Inspection/Surveys in Arkansas and Texas as Compared to That Shown in the Medicare/Medicaid Automated Certification System (MMACS) ACN: 06-50161

To G. A. Rafalko
Regional Inspector General for Audit, Region III

The purpose of this memorandum is to provide you the results of our audit work in response to your memorandum of February 5, 1985, to Mr. Larry Simmons regarding the " Nursing Home Project." Your memorandum indicated that as of December 31, 1984, MMACS data showed that Arkansas and Texas had some 87 and 218 ICFs and 57 and 68 SNFs, respectively that had not been inspected in the last 15 months.

Our review at HCFA's Region VI Health Standards and Quality (HS&Q) Division has shown that the inspection/survey dates reflected in MMACS as of December 31, 1984, were significantly inaccurate and out of date. Consequently, MMACS data did not properly reflect the inspection status of nursing homes in Arkansas or Texas. Our sample of 12 SNF and 12 ICF nursing homes in Texas and Arkansas showed (1) that each facility had been inspected/surveyed subsequent to the dates shown in MMACS as of December 31, 1984, and (2) that these facilities were surveyed within the time frames mandated by the regulatory provisions of the Department. Specifically, our test showed that 43 of the 48 nursing homes sampled had been inspected/surveyed during 1984 and that the other 5 nursing homes had been surveyed during the period October through December 1983. While documents were not available within HCFA at the time of our review to show whether five nursing homes had also been inspected in late 1984, we have every reason to believe these homes had been surveyed in 1984 based on the history of prior record of inspections.

Based on the results of our tests, we believe that nursing homes identified in your audit request for Texas and Arkansas have been surveyed in accordance with applicable regulations.

Region VI HS&Q officials have recognized that MMACS data is unreliable and out of date and that the system's usefulness as a management tool is significantly limited. These officials indicated that several factors have contributed to the problem. These factors include (1) complex edits which make data input difficult to accomplish and (2) reductions in personnel which have caused the regions to shift resources to higher priority workloads.

Within the past two or three months, Region VI's HS&Q Division has assigned one staff member full time to updating and correcting the MMACS data. As a result, MMACS data entry exception backlogs have been reduced by about 60 percent.

If you need any additional information, please advise.

Glyndol J. Taylor
GLYNDOL J. TAYLOR

cc: Austin Field Office
Little Rock Field Office

DEPARTMENT OF HEALTH & HUMAN SERVICES REGION III

Memorandum

Date APR 23 1985

From Regional Inspector General for Audit

Subject Request for Legal Opinion - Timeliness of Surveys and Certifications in Long Term Care Facilities

To Assistant Inspector General for Audit

Current surveys in three states show that Medicaid Agencies have not been surveying and certifying Long Term Care Facilities in accordance with applicable laws and regulations. We believe this situation resulted from the Medicaid Agencies failure to comply with 42 CFR 442.12 which stipulates that Medicaid Agencies may not execute a provider agreement with a Long Term Care Facility for skilled or intermediate services nor make Medicaid payments to a facility unless the surveying agency has certified the facility to provide those services. The provider agreement is generally for 12 months but under certain circumstances may be extended an additional 2 months.

We intend to recommend recovery of Federal funds for services to Medicaid recipients in Long Term Care Facilities that were not surveyed and certified in accordance with Federal law and regulations. The situation, however, becomes somewhat clouded because of actions taken by the Health Care Financing Administration (HCFA) during periods when Federal funding for survey and certification activity was restricted.

We are requesting a legal opinion on certain aspects related to the above issue. Specifically, we are interested in determining if our intended recommendation to deny Federal funds for services to Medicaid recipients in Long Term Care Facilities that were not surveyed and certified in accordance with Federal law and regulations is appropriate given the actions of HCFA. To assist, we are providing some background information, including statutory and regulatory citations.

*** *** ***

Results of Survey

In response to a request from the United States Senate Special Committee on Aging we began a review of Long Term Care Facilities nationally. Our primary objective related to quality of care being provided in the Long Term Care setting. Subsequently, we became aware of a problem that could result in large dollar recoveries. The basis of the recovery being that Long Term Care Facilities were not being surveyed and certified every 12 to 14 months as required by Federal law and regulations.

The following citations, we believe, support our contention that Long Term Care Facilities must be surveyed and certified within a 12 to 14 month period.

1. Section 42 CFR 442.15 - Duration of Agreement - states:

   (a) Except as specified under §442.16, the duration of an agreement may not exceed 12 months.

   (b) The agreement must be for the same duration as the certification period set by the survey agency. However, if the Medicaid agency has adequate documentation showing good cause, it may make an agreement for less than this period.

   (c) FFP is available for services provided by a facility for up to 30 days after its agreement expires or terminates under the conditions specified in §441.11 of this subchapter.

2. Section 42 CFR 442.16 - Extension of Agreement - states:

   A Medicaid agency may extend a provider agreement for up to 2 months beyond its original expiration date if it receives written notice from the survey agency, before the expiration date of the agreement, that extension will not jeopardize the patients health and safety, and -

   (a) Is needed to prevent irreparable harm to the facility or hardship to the recipients in the facility, or

   (b) Is needed because it is impracticable to determine, before the expiration date, whether the facility meets certification standards.

3. Omnibus Reconciliation Act of 1981 (Public Law 97-35, Section 2153) deleted the requirement for annual inspection for Long Term Care Facilities participating in the Medicare program. Implementing regulations were never issued.

Three states in our survey have been identified as not having timely survey and certifications for various categories of Long Term Care Facilities during the most recent four years. They are Indiana, Illinois, and Connecticut. Information on each state follows.

Indiana

The review disclosed substantial non-compliance with both certification and provider agreement requirements of the Medicaid program. A total of 230 facilities, out of 347 facilities reviewed, operated without effective certifications for varying periods of time between June 1, 1982 and March 31, 1984, because the survey agency had not conducted recertification surveys.

Federal payments made to these facilities during this period amounted to about $41.3 million.

Illinois

The review of Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) indicated that 7 of the 12 state operated facilities were not surveyed and certified in accordance with Federal law and regulations. It is estimated that about $6 million in Federal payments were made during the period when the facilities were out of compliance.

Connecticut

The review disclosed that 17 of the 77 Long Term Care Facilities reviewed were not surveyed and certified timely. The Federal payments made during the periods of non-compliance amounted to about $3.2 million.

HCFA Activities To Enforce Laws and Regulations

HCFA has taken various actions over the past several years in regard to enforcing the law and regulations dealing with survey and certification. Prior to the enactment of the Omnibus Reconciliation Act of 1981, HCFA fully enforced the "time limit agreement" requirement outlined in 42 CFR 442.15. Since the enactment of Public Law 97-35 and severe budget reductions for state survey and certification activity HCFA has changed emphasis - without issuing implementing regulations. As a reaction to Public Law 97-35 and budget reductions HCFA published statements such as the following:

1. "Regional Health Standards and Quality Letter" prepared by HCFA Regions in November 1981

   In Section 2153 of the Omnibus Reconciliation Act of 1981 (P.L. 97-35), Congress deleted from the Social Security Act the requirement that an agreement with a skilled nursing facility not exceed 12 months. With this, Congress expressed its clear intent that annual surveys are unnecessary for some facilities.

   This statement of Congressional intent was reinforced when Congress passed the current appropriation for the State Certification Program. There could be no clearer expression of intent that for Congress, through the budget process, to make it impossible to survey all facilities on an annual basis. Thus, while regulations currently in force stipulate annual surveys, the change in law, cited above, reinforced by the appropriation, supersedes regulations. This gives HCFA the authority to implement flexible survey cycles.

   If you have any questions on flexible survey cycles, please contact your State liaison person.

2. Memorandum From Director of Health Standards and Quality Bureau To All Regional Offices Dated in January 1983

During the last quarter of 1981, we issued memoranda addressing the reduction in survey activities, the scheduling of surveys during the 1982 fiscal year, and the rationale for implementing flexible survey cycles on an interim basis. The major thrust of the memoranda was that Congress had expressed its intent that annual surveys were unnecessary for all facilities by repealing the statutory basis for time-limited agreements (TLAs), and by passing an appropriation for the State Certification Program that would not support annual surveys for all facilities. Accordingly, we suggested a methodology for prioritizing and allocating survey resources and authorized the selective extension of existing provider agreements.

Since the May 27, 1982 publication of proposed Subpart S [1/] changes, Congressional commentary, the imposition of a moratorium on the proposed rules, and the passage of a larger appropriation is indicative of a change in Congressional intent from that described earlier. In light of these factors, and because funding is now at a level to support issuing 12 month agreements and conducting annual surveys of all long-term care providers, it is encumbent on us to move toward stricter compliance with all the regulatory provisions, especially Subpart S. The same course would necessarily follow for Title XIX facilities.

We appreciate the difficult logistical problems your States will encounter in gearing up for full implementation. A liberal phase-in period would be expected under the circumstances.

3. Memorandum From the Director, Health Standards and Quality Bureau To Each Regional Office Dated in August 1984.

Reports of recent findings indicate some inconsistency among Regions in implementing time limited agreements and other Subpart S requirements. As I noted in my January 27, 1983 memorandum, the conditions under which we implemented interim policies for flexible survey cycles for long-term care facilities have changed.

It is clear that Congressional intent and the commitment of the Administration is to enforce the requirements of Subpart S. In my January 1983 memorandum, I noted that due to the logistical problems we would allow a liberal phase-in period for returning to full compliance with Subpart S. I would expect that by this time we would be in full compliance with all provisions. If you have not yet returned to full compliance, you should move aggressively toward that end.

[1/] Subpart S is entitled "Certification Procedure for Providers and Suppliers of Services", and is the section of regulations which outlines the certification process for all types of providers and suppliers.

It becomes clear from these documents and other HCFA actions that the lack of annual survey and certification activity was to some degree condoned by them. These actions which appear to be in conflict with published regulations lead us to seek a legal opinion as to whether the states can be held to published regulations despite the actions of HCFA.

Questions to be Addressed

1. When law and regulations differ such as the case we have with the Omnibus Act of 1981, which would take precedent?

2. Can HCFA deviate from published regulations by issuing informal memoranda such as the examples presented?

3. Is the fact that states deviate from the issued regulations a sufficient basis to recommend a financial recovery from the states involved?

4. If in fact the states are required to follow the issued regulations can HCFA "waive" the questioned Federal share in this instance? If yes, on what authority could this be done?

5. Does HCFA have the authority to suspend issued regulations such as those dealing with survey and certification. If yes, on what authority could this be done?

6. Are we on sound grounds if we recommend a financial recovery? Before the January 27, 1983 HCFA memo? After the January 27, 1983 HCFA memo?

We appreciate your assistance. Please call if you have any questions.

G. A. Rafalko

G. A. Rafalko

cc: Larry Simmons

April 24, 1985

Thomas G. Wallner
Associate Regional Administrator
Division of Health Standards & Quality
Health Care Financing Administration
2901 Third Avenue, MS 409
Seattle, Washington 98121

Dear Mr. Wallner:

This letter serves to reaffirm our commitment to quarterly meetings with Region X, Division of Health Standards and Quality. These collective meetings have enhanced communication and program administration over the years.

A review of past minutes reveals the value of our meetings:

- Productive discussion on revising the 1864 Agreement
- Implementation of federal program requirements for nursing homes, ICFs/MR, and hospitals; e.g., PaCS and Drug Regimen Review Training
- MMACS and Washington's certificaton computer project
- Four-state letter of support for retaining a regional office in Seattle, Washington
- Budget considerations
- Discussion of important issues and problems; e.g., the Institute of Medicine study

It is our understanding that recently you told the representative for Region X states that you were not interested in continuing participation in these quarterly meetings. Given the importance of our quarterly meetings and the benefits to all parties, we are hopeful that there has simply been some misunderstanding and that quarterly meetings will be resumed.

RECEIVED
[illegible]

We have established a tentative meeting date and agenda for the next quarterly meeting. We will be glad to add any agenda items you may have and are willing to reschedule the meeting date, time, and place to accommodate you.

We look forward to hearing from you soon and to continuing our mutual efforts to improve health care services.

Yours for improved patient care,

Conrad Thomp[illegible]
Director LTC, Washington

Director Non-LTC, Washington

Jean Schoonover
Director, Idaho

Director, Oregon

Director, Alaska

Enclosure: Agenda

/de

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit
Region IX

Memorandum

Date May 2, 1985

From OIG, Office of Audit

Subject Expansion of National Review on Survey and Certification Activities at Intermediate Care Facilities - Oregon

To G.A. Rafalko
Regional Inspector General
for Audit
Gateway Building
3535 Market Street, Room 10250
Philadelphia, PA 19104

This memorandum presents the results of our review on the timeliness of surveys and certifications of Medicaid Intermediate Care Facilities in Oregon. We have reviewed the facilities on the Rapid Data Retrieval System (RADARS) listing that you provided us. The listing indicated that, as of December 31, 1984, 82 facilities had not had a survey in the last 14 months.

Our review showed that the RADARS listing was not accurate because HCFA was not updating the information on completed surveys in a timely manner. Our review of individual provider files at HCFA disclosed that 32 of the 82 facilities had not been surveyed within the 14-month period. In addition, 32 of the 82 facilities had intervals between the the most recent survey and the previous one that exceeded 14 months.

We found that on November 20, 1981, the HCFA Division of Health Standards and Quality (DHSQ), Region X, issued State Letter No. 101 which stated that it would no longer require annual resurveys or issue time-limited agreements. This letter also permitted survey intervals to be as long as 36 months (See Attachment 1). These provisions were rescinded by Region X, DHSQ State Letter No. 170 dated February 15, 1985 (See Attachment 2).

If you have any questions please contact Ron Yee or Dan McNulty at 556-7004.

James O. Payne
for HERBERT WITT
Regional Inspector General
for Audit

Attachments

[COMMITTEE STAFF NOTE: Attachments are located elsewhere in this chronology of DHHS internal documents.]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Region X
M/S 409
2901 Third Avenue
Seattle, WA 98121

May 3, 1985

Conrad A. Thompson, Director
Bureau of Nursing Home Affairs
Department of Social and Health Services
Mail Stop OB-31
Olympia, Washington 98504

Dear ~~Mr. Thompson~~ Conrad:

Thank you for your letter of April 24. I appreciate your comments regarding the value of our quarterly meetings.

As discussed with Jean Schoonover recently, we are planning to meet with each state over the next few months, either in conjunction with our SAEP visits or at other times. These meetings, we believe, will allow ample opportunity to discuss all appropriate topics, and in addition, will allow DHSQ management to focus in more depth on the specific concerns of each state.

Please be assured we are committed to continuing and enhancing communication with each state. I look forward to meeting with you in the near future. In the meantime, please continue to feel free to give me a call whenever issues and/or questions arise requiring immediate attention.

Sincerely,

Thomas G. Wallner
Associate Regional Administrator
Division of Health Standards and Quality

cc PM:
Jerry Billy
attach state letter

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL
REGION I

Memorandum

Date MAY 7 1985

From Edward A. Parigian
Regional Inspector General for Audit

Subject Results of Review on Survey and Certification Activities at Skilled and Intermediate Care Nursing Homes - Audit Control Number 01-52011

To Gervus A. Rafalko
Regional Inspector General for Audit

In accordance with your request of February 27, 1985, we have completed our review to determine whether nursing homes in Massachusetts and Connecticut are not being surveyed in accordance with Federal regulations and, therefore, are not eligible for Federal financial participation in the Medicaid program. The listings you provided to us contained only 1983 or earlier data. We queried HCFA's Medicare/Medicaid Automated Certification System (MMACS) for the latest survey dates. In most instances, surveys had been done during 1984.

The following sections of this memorandum summarize the results of our review in Massachusetts and Connecticut. Please refer to the ATTACHMENT for our answers to the nine questions contained in your audit guide.

Massachusetts

We determined that all 232 skilled and intermediate care nursing homes on your listing had timely surveys and were appropriately certified to participate in the Medicaid program. Concerning the 12 intermediate care facilities for the mentally retarded (ICFs/MR) on your listing, we found that Federal court orders over the past several years have necessitated rigorous monitoring of conditions by State and Federal officials. In view of this, we do not believe it appropriate to review these facilities further at this time.

Massachusetts operates under a waiver granted by the HCFA Office of Research and Demonstrations (ORD) under which the State was authorized to perform three levels of surveys dependent on the facilities' prior history of a compliance with health and life safety standards. The waiver was originally granted during 1981 for a one year period. However, annual approvals have extended the waiver through 1985. The three levels of surveys are:

1. Screening Survey - If the facility has met at least 95 percent of compliance criteria for at least three years the survey will focus on particular problems rather than a more complete survey as enumerated below.
2. Abbreviated Survey - Facilities that have compliance scores of at least 85 percent with patient care related regulations since 1977 will be surveyed according to the usual procedures but against a reduced number of criteria.
3. Full Survey - The State agency must perform a comprehensive survey of facilities that were decertified for patient care under current ownership and all those facilities that have had compliance scores below 85 percent.

Our review of HCFA and State agency records showed that surveys were completed in accordance with the waiver and where conditions of participation were not met, the State agency followed the proper precedures in notifying those facilities of the unmet standards. Timely follow-up inspections were made to verify that proper corrective actions were taken.

Connecticut

We determined that 17 of the 77 facilities on your listing were not surveyed in accordance with the 14 month period specified in your February 27, 1985 memorandum, resulting in unallowable Medicaid payments to these facilities totalling about $6.4 million (Federal share $3.2 million). The 17 facilities were not surveyed in a timely manner because, according to State agency officials, Section 2153 of the Omnibus Budget Reconciliation Act of 1981 deleted the requirement for annual surveys under both Medicare and Medicaid. In our opinion however, since Section 2153 only applies to Section 1866(a)(1) of the Social Security Act, and Section 1866 applies only to Medicare, the State agency was still required to perform annual surveys on Medicaid facilities. (Refer to the EXHIBIT for detailed information concerning the periods not surveyed for each of the 17 facilities and the amounts paid to them from Medicaid.)

State agency officials informed us that HCFA had approved their doing less than annual surveys due to budget reductions resulting from the Omnibus Budget Reconciliation Act. Our discussion with regional HCFA officials disclosed that HCFA had approved the State's budget for survey and certification functions. The State's budget had listed, as attachments, the frequency of the surveys for each facility. The facilities were scheduled to have surveys done on intervals of nine to 24 months. The records clearly indicate that HCFA had approved these budgets as submitted by the State agency. This situation existed during 1982 and 1983. For 1984, all surveys, for the facilities on your listing, were being conducted according to Federal regulations.

We believe that a legal opinion from the Office of General Counsel is necessary to determine whether HCFA had the authority to act contrary to Federal regulations requiring annual surveys. In the event that HCFA did not have this authority, OGC should also determine whether the State agency should refund the Federal share of the Medicaid payments made to those facilities that were not surveyed according to Federal regulation.

Regional HCFA Administration

HCFA's Health Standards and Quality Bureau (HSQB) relies on MMACS to track State agency progress in meeting survey dates and highlight facilities that have consistent patterns of deficiencies. In Region I, MMACS had up to a five month backlog of data prior to 1984. During 1984, HCFA added additional personnel to input regional data and currently data is input, for the most part, on a monthly basis.

HCFA also performs annual State Agency Evaluation Program (SAEP) reviews which includes a review of survey and certification performance by the State agencies. Under the SEAP, HCFA samples State agency files checking timeliness of surveys, processing time, survey dates, conformance to HCFA certification policies and budgetary matters. HCFA also reviews prior years findings on facilities to determine whether corrective actions have been taken.

We found, however, that in about 10 percent of the facilities we reviewed that HCFA's files were missing survey and/or certification dates. These dates were obtained from a review of State agency files which we found to be more complete than HCFA's files. We are not able to determine whether the state agencies forwarded this information to HCFA or whether HCFA recieved the information and misfiled the forms.

In the event that you need any further information or have any questions on our review, please do not hesitate to call William Hornby or Arnie Goldie of my staff at (FTS) 223-1045.

Edward A. Parigian
Regional Inspector General
for Audit

cc: F.J. Majka, AIGA
L.K. Simmons, HCFAD

EXHIBIT

INFORMATION ON CONNECTICUT NURSING HOMES NOT SURVEYED AS REQUIRED BY FEDERAL REGULATIONS

Name of Facility	Type of Facility	Period Not Surveyed	Medicaid Payments for Period Not Surveyed	
	SNF	12/1/82-11/30/83	$ 354,580	(1)
	ICF	11/1/82-10/31/83	221,148	(1)
	ICF	2/1/83-7/31/83	153,053	(1)
	ICF	10/1/82-9/30/83	454,545	(1)
	ICF	3/1/83-12/31/83	355,321	(1)
	ICF	4/1/82-9/30/82 10/1/83-3/31-84	141,273	(1)
	ICF/MR	3/1/83-11/30/83	1,200,530	(1)
	ICF/MR	7/1/83-4/30/84	416,911	(1)
	ICF/MR	8/1/83-10/31/83	77,136	(1)
	ICF/MR	9/1/83-8/31/84	544,716	(1)
	ICF/MR	4/1/83-11/30/83	297,992	(1)
	ICF/MR	7/1/83-2/28/84	283,089	(1)
	ICF/MR	7/1/83-11/30/83	806,432	(1)
	ICF/MR	2/1/83-11/30/83	142,558	(1)
	ICF/MR	2/1/83-7/31/84	330,185	(1)
	ICF/MR	11/1/82-8/31/83	478,034	(1)
	ICF/MR	4/1/84-5/31/84	101,294	(2)
	Total Medicaid Payments		$6,358,797	

Notes:

(1) The State agency signed an agreement with the facility covering an unspecified period of time. The period not surveyed is in excess of the time allowed under Federal rgulations. The State agency informed us that they believed that the Omnibus Budget Reconciliation Act removed the requirement for annual surveys of Medicaid providers. In our opinion, however, the section of the Act they quote applies only to Medicare, therefore, the nursing homes should have been surveyed annually.

(2) This facility had deficiencies during the period covered by our review. Several short-term agreements (three month duration) were signed while the facility attempted to correct the deficiencies. The period not surveyed represents two months not covered by a provider agreement.

ATTACHMENT
Page 1 of 3

Question #1

Determine current status of State surveys for all nursing homes included on listings.

Response #1

All nursing homes on your listing, with the exception of the Massachusetts ICFs/MR mentioned earlier, have had surveys covering the current period. We found that only a relatively small number of surveys had not been entered into MMACS and this was because it takes about 30 days for the data to be processed by the regional office.

Question #2

For those homes that were either updated since December 31, 1984 or have survey reports in the regional office but not on the system, determine if the 14 month requirement was met for both survey periods. If the requirement was not met, then further work is required at the State agency to determine if a financial adjustment is warranted.

Response #2

The 14 month requirement was met for all Massachusetts facilities on your listing. We found that 17 Connecticut facilities were not surveyed within the 14 month timeframes you specified. Refer to the EXHIBIT for the periods not surveyed for each of the 17 facilities.

Question #3

Determine through interviews if MMACS is used as a management tool to monitor State survey functons. If not, why not? Check for any policies and procedures on updating MMACS which could effect its use as a management tool.

Response #3

HCFA's HSQB relies on MMACS to track State agency progress in meeting survey dates and highlights facilities that have consistent patterns of deficiencies. In Region I, MMACS had up to a five month backlog of data entry prior to 1984. During 1984, HCFA added additional personnel to input regional data and currently data is input, for the most part, on a monthly basis.

HCFA also performs annual SAEP reviews which includes a review of survey and certification performance by the State agencies. Under SAEP, HCFA samples State agency files checking timeliness of surveys, conformance to HCFA certification policies and budgetary matters. HCFA also reviews prior years findings on facilities to determine whether corrective actions have been taken.

Question #4

Determine through interviews and record what actions, including withholding of Federal funds, HCFA has taken to ensure that nursing homes are surveyed annually.

Response #4

HCFA did not monitor the State of Connecticut to determine whether they were performing surveys annually since they had approved the State agency's request to do surveys on other than on an annual basis. As a result, they were not aware of homes being unsurveyed for periods in excess of that allowed by Federal Regulations.

Question #5

Determine if nursing homes out of compliance according to HCFA records, were, in fact, out of compliance. In other words, were surveys made within Federal timeframes?

Response #5

The Connecticut facilities listed on the EXHIBIT were not surveyed in accordance with Federal regulations. We confirmed this by reviewing State agency records and discussions with State agency officials.

Question #6

For those nursing homes out of compliance, identify all Federal funds reimbursed to the homes during periods of non-compliance. Report financial adjustment separately for each survey period, with the current period ending February 28, 1985, for reporting purposes.

Response #6

Refer to the EXHIBIT for detailed information concerning nursing homes determined to be out of compliance with Federal regulations.

Question #7

For those nursing homes that were surveyed within Federal timeframes, determine if the State agency forwarded material to HCFA. On a seleted basis trace a few back to HCFA and determine why no input to MMACS.

Response #7

We found that in about 10 pecent of the facilities we reviewed that HCFA's files were missing survey and/or certification dates. These dates were obtained from a review of State agency files which we found to be more complete than HCFA's files. We were not able to determine whether the State agencies forwarded this information to HCFA or whether HCFA received the information and misfiled the forms.

Question #8

If surveys were not made as required, determine why not through interview. Do State officials interpret Federal regulations differently?

Response #8

As stated earlier, State agency officials interpreted the Omnibus Budget Reconciliation Act to exempt both Medicare and Medicaid facilities from annual surveys. However, the Act only refers to Medicare.

Question #9

Through interviews, determine if the State agency has been contacted by HCFA officials regarding timing of surveys, performance of surveys, etc.

Response #9

Surveys in Massachusetts and Connecticut are being performed on a current basis. However, HCFA officials informed us that should the surveys fall behind, MMACS will indicate which facilities are overdue and the State agency would be contacted to determine when the surveys would be done. During 1982 and 1983, the State of Connecticut was performing less than annual surveys under HCFA's approval. In 1984, the State began doing annual surveys and is current for the facilites on your listing.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of General Counsel

Region X
M/S ______
2901 Third Avenue
Seattle, WA 98121

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STATISTICS STANDARDS
AND LOCAL HEALTH SERVICES

RECEIVED
MAY 17 1985
OFFICE OF THE ATTORNEY GENERAL
HEALTH & WELFARE DIVISION

May 13, 1985

Curt Fransen
Assistant Attorney General
State of Idaho
450 W. State, Tenth Floor
Boise, Idaho 83720

Re: Advice to Surveyors on Guidelines

Dear Mr. Fransen:

As we discussed today on the telephone, I am enclosing a statement on Federal Interpretive Guidelines and Survey Procedures for surveyors.

If the statement reflects your views on the subject, would you be willing to jointly issue it with me, as our combined state/federal advice on the subject?

Let me know if you want to change anything. My number is (206)442-7309.

Sincerely,

Evelyn McChesney

Evelyn McChesney
Assistant Regional Attorney

Enclosure

Federal Interpretive Guidelines and Survey Procedures

1. Surveyors should do the things specified in the right-hand column of the Guidelines, i.e., the procedures should be followed. Surveyors should be able to respond "yes" when asked, "Did you interview the people indicated in the Guidelines? Did you look at the records indicated in the Guidelines? Did you observe the specific things you were requested to observe? Did you read what you were asked to read?"

2. Surveyors should collect the information and make the professional determinations called for in the middle column. If a deficiency is found, because the facility does not meet a Guideline, that information should be written down. For example, information should be collected and any deficiencies noted on the patients' fluid balance, elimination, electrolyte status, respiratory status, functional capacity of musculature, neurologic status, and nutritional status. [SNF Guideline, p. 51]

3. If deficiencies are found in the Interpretive Guidelines which are sufficient to put the condition out of compliance, cite the regulation, in the left-hand column, as not met.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit
REGION IV
101 MARIETTA TOWER, SUITE 1421
ATLANTA, GEORGIA 30323

Memorandum

Date MAY 15 1985

From Regional Inspector General
for Audit, Region IV

Subject Report on Survey and Certification Activities at Skilled Nursing Facilities in Mississippi - ACN: 04-50151

To Regional Inspector General
for Audit, Region III

In accordance with your November 15, 1984, request, we have reviewed the 13 Mississippi skilled nursing facilities (SNF) which met Region III's selection criteria of not meeting important conditions and standards for a long period of time. In addition, we reviewed five other SNFs which were recommended by the single state agency and the state survey agency as having a history of non-compliance with conditions of participation.

Our review was performed primarily to determine (1) the current status of the facilities, (2) how long the identified deficiencies existed, (3) action taken or planned to improve or terminate the facility, and (4) whether the facilities warrant a site visit. The review was performed at the HCFA-HSQ Regional Office; the Mississippi Health Care Commission (MHCC), the state survey agency; and the Governor's Office, Division of Medicaid (DM), the single audit state agency responsible for the Medicaid program.

Our review consisted of obtaining updated MMACS survey data and evaluating the survey and certification procedures and the certification files on the 18 SNFs at the HCFA-HSQ Regional Office, the MHCC and the DM. We also visited 2 of the 18 SNFs. The review was performed in accordance with the applicable "Standards for Audit of Governmental Organizations, Programs, Activities, and Functions" as considered necessary under the circumstances. The field work was performed between January 1985 and April 1985.

Most of the facilities had a history of repeated deficiencies and periods of temporary but recurring non-compliance with the conditions of participation. Many of these facilities also showed either a continuous line of improvement since 1981 or were just as likely to be in compliance 100 percent on any one day and have a number of conditions or standards out of compliance the next day. At the time of our review, all 18 SNFs had current had current Medicaid agreements and were in compliance with the conditions of participation ranging from marginal to full compliance. None of the SNFs' situations appeared to pose life-threatening dangers to the patients.

Both MHCC and DM personnel believe it is change that has contributed to the improvement, whether it is a change of ownership or a new administrator or director of nurses. Both State agencies' personnel also agree that the one thing that catches the errant providers' attention quicker than anything else and produces fast Plans of Corrections are the sanctions which the Division of Medicaid's Director has the authority to impose when necessary, which are:

(1) Prohibit patient admissions.

(2) 10 percent reduction in the facility's reimbursement rate.

(3) Deduction from next payment check for past disallowances.

The situation and the chain of events at the Nursing Center will demonstrate the effectiveness of Mississippi's system. During the four years 1981 through 1984, Hotel Reed had 87, 216, 26 and 19 deficiencies, respectively. A March 13, 1985, resurvey showed that Hotel Reed met all conditions of participation. The survey cited 16 standard deficiencies, none of which were considered life-threatening.

The improvements at occurred as follows:

(1) In October 1981, MHCC initiated action to revoke the license and to terminate Medicaid participation. The owner requested a hearing and a date was set. The week before the hearing was scheduled the owner filed bankruptcy.

(2) DM advised MHCC and the court that the 73 Medicaid patients in the home could not be relocated because there were no beds available in the entire state. As a result, the Medicaid agreement was extended through December 31, 1981; the home was placed in receivership; the owner and his family were ordered out of the facility; and a competent administrative team was placed as receiver. The MHCC gave the home a provisional license through May 31, 1982, and DM issued a 6-month restricted agreement also ending May 31, 1982.

(3) On April 26, 1982, changed ownership and a new agreement was issued on June 1, 1982.

(4) MHCC conducted a survey on May 12, 1982. Nine (9) Conditions were considered not met on this date -- primarily due to the fact that the new owner had not been there but a couple of weeks and could not officially enter into binding agreements with Medical Director, Social Work Consultant, Patient Activities Consultant, etc. Also, to further compound the situation, illegal drugs were being distributed by patients and staff. Federal and State agents were observing these practices and requested that MHCC not get involved with these particular patients and staff. The new owner could not fire or suspend these employees while this investigation was in progress. These employees had not and were not doing their job. However, remedies could not be taken. Most of the deficiencies cited were a result of the construction or maintenance of the building, documentation of care, and required paper work.

The facility had new qualified management, new Registered Nurses in sufficient number, a full-time Registered Dietitian, and other employees. There was also a commitment on the part of the owner that all deficiencies relating to patient care would be corrected by September 1982, and that all deficiencies related to Physical Environment would be corrected by May 1983.

(5) was recertified based on their Plan of Correction and MHCC scheduled a follow-up visit in September 1982.

(6) The DM and MHCC made numerous visits during the three months prior to the follow-up visit to review progress in correcting the cited deficiencies. The September 28 and 19, 1982 follow-up visits showed that all conditions of particiption were met and construction and renovation was well underway. The patients were happy and were receiving good care.

(7) As was shown by the March 13, 1985 resurvey, the Nursing Center has continued to improve.

In our evaluation of the State survey agency's survey and certification procedures, we found the surveys to be timely, the surveyors generally consistent and thorough in implementing the survey procedures, which ranged from citing deficiencies and pursuing acceptable plans of correction to investigating grievances and initiating termination procedures.

In the evaluation of the HCFA-HSQ Federal files, aside from the "Look Behind" review (which the State survey agency then takes over and notifies providers of the deficiencies, pursues the plan of correction and does the follow-up visits), there was nothing to indicate HCFA-HSQ wielded any significant impact in dealing with consistently errant Medicaid-only providers. Letters from HCFA-HSQ to the providers reiterated sanctions imposed on the facilities after being notified by the State survey agency or Medicaid that such sanctions were being imposed. One Federal file contained notes of the survey packet review by one of HCFA-HSQ's personnel; HCFA-HSQ reviewers had concerns over the survey procedures and the State survey agency's recommendation to Medicaid for renewal of the provider agreement. However, we could find no evidence of these concerns being relayed to the State survey personnel. The provider agreement was renewed for another 12 months.

We found nothing to indicate that significant information had not been forwarded to HCFA-HSQ. The surveyors were generally consistent in survey procedures with the exception of allowing conditions to remain out of compliance longer than 45 days from the survey date. However, the surveys were scheduled approximately 3 months prior to the expiration of the current 12-month provider agreement and by then the facilities generally met the compliance requirements of the conditions of participation or termination procedures were initialed. Termination generally ceased before the entire process was completed, which could take up to two years, because the facilities met the compliance requirements prior to that time.

Facilities reviewed appear to not warrant site visits nor did medical consultants need to be involved. Nevertheless, we visited two facilities which we considered conducive for life-threatening non-compliance conditions to exist at any time. We found nothing at either faciity to indicate to us, or the RN-MHCC health facility surveyor who accompanied us on the unannounced visits - that the quality of care was diminished so as to cause life-threatening dangers to the patients.

On August 30, 1984, the Mississippi Legislature's Joint Committee on Performance Evaluation and Expenditure Review (PEER Committee) issued a report on "A Review of Selected Areas of Operation of the Mississippi Medicaid Program." The review was performed in response to a general concern that ICFs and SNFs may be reducing expenses by reducing the quality of direct patient care provided on late evening and early morning shifts. PEER staff and MHCC staff jointly performed unannounced evening inspections in 26 nursing homes located across the State. That review resulted in the following conclusions and recommendations:

Conclusions

"1. Even though twenty of the twenty-six nursing homes received one or more deficiency citations, there does not appear to be a uniform pattern of neglect of direct care conditions and standards for late evening and early morning shifts. The majority of the citations issued dealt with areas of operation which do not pose an immediate health or safety hazard to patients.

"2. A review of prior deficiency inspection files and complaints issued against the nursing homes chosen for night inspections reveals a chronic pattern of recurring deficiencies in approximately one-fourth of the homes reviewed. In highly simplified form, the following sequence appears to occur: Health Care Commission staff identifies a deficiency and requests a plan of correction; the home submits the plan and takes steps to implement it; the Health Care Commission staff revisits the home to confirm compliance; and finally, the deficiency is classified as corrected if sufficient progress has been made. However, this does not appear to be the end of the sequence. PEER staff, in its file review of the twenty-six nursing homes, identified at least 172 instances of recurring deficiencies on subsequent inspections after initial identification of a problem."

Recommendations

"1. The Health Care Commission should provide periodic, random evening/night reviews of a cross-section of nursing homes as a regular component of its inspection program and use the results of such inspections as an indicator of direct care monitoring needs for individual homes.

"2. The Health Care Commission and Division of Medicaid should coordinate their nursing home survey/inspection efforts. Information from the surveys should be utilized by the Division of Medicaid to aggressively impose economic sanctions to elicit compliance and long-lasting correction of deficiencies from those homes that are in violation of elements, standards, or conditions of participation."

In your audit request, four Region IV States (Mississippi, Alabama, Georgia, and Kentucky) were targeted for review. We do not want to express an opinion or make recommendations on Region IV's SNF's based on our review of Mississippi alone. We are reviewing Alabama's SNFs; the entrance conference was held April 11, 1985.

If you have any questions or wish to discuss this matter further, please contact Gary Furlong on FTS 242-2113.

Sincerely,

Emil A. Trefzger, Jr.

STATE OF IDAHO
DEPARTMENT OF HEALTH AND WELFARE
FACILITY STANDARDS PROGRAM
420 West Washington Boise ID 83720-9990 (208) 334-4169

May 22, 1985

Thomas G. Wallner
Associate Regional Administrator
Division of Health Standards & Quality
Region X - HHS M/S 409
2901 Third Avenue
Seattle WA 98121

Recently I was informed by Conrad Thompson that during a conversation he had with you that you expressed your continued commitment to quarterly meetings of the state directors of Licensing and Certification in the four Region X states. He further informed me that it was your desire at this time to focus upon individual state issues as much as possible and are scheduling visits to each state for that purpose.

As representative for the four states, I can assure you that we understand, encourage, and appreciate your approach to individual state meetings. We also believe the quarterly meetings of the four state directors together with regional office representatives are essential and look forward to reconvening such meetings this Fall. In the meantime, the four state directors plan to meet in July to discuss issues of mutual interest regarding Medicare, Medicaid, and Licensure. We would find the meeting to be more beneficial if at least one of your staff, or preferrably you, could attend to assist us in better understanding some of the federal issues to be discussed.

I would appreciate a response to this letter confirming my understanding of your intention to resume quarterly meetings this Fall and whether or not you or a staff person could attend our July meeting.

We recognize the limitations of staff and time that you as well as the states are experiencing and appreciate the efforts being made to keep communications and contacts open.

Jean

Jean Schoonover, R.N.
Region X AHFLCD Representative

JS/nh

cc: Bee Biggs, R.N.
Maureen Whitman
Conrad Thompson
John Gerth
Karen Martz

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date JUN 3 1985

From Sharon Harris
Sharon Harris, Acting Director
Office of Survey & Certification

Subject Front-End Data Entry and Case Control System

To Associate Regional Administrators
Division of Health Standards & Quality
Regions I - X

Based on your comments at the recent ARA conference and your suggestions in response to our March 19 memorandum, we are revising the front end data entry screens and case control reports in the following areas:

- Critical Requirements and Conditions of Participation (COPs)

  We have decided to add both statutory requirements not already included as COPs or Critical requirements and health/safety waivers to the front-end data screens. This involves an additional 21 data tags for SNFs, 1 data tag for ICFs, 3 data tags for hospitals for the statutory requirements, and a check of 1 data tag (L12) for all provider types for the waivers (see Attachment A). We will not, however, supplement these flags with region-specific flags. We want the front-end flags to represent uniform criteria for all regions.

- RO Approval Date

  In response to several requests, the RO approval date (L33) for all Medicare facilities having no health and safety deficiencies will be automatically supplied by MMACS when the recertification kit is entered. The MMACS-generated RO approval date will be the date the kit is entered into MMACS. Once this change is in place, the number of cases requiring a separate entry of the approval date will be significantly reduced.

  It has come to our attention that some regions are recording a dummy L33 approval date for Medicare facilities at the time a case is entered into MMACS so that it will be accepted directly to the Master file. This practice should be discontinued because it distorts the information on the case control reports by showing all cases as being cleared including flagged cases that have not yet been reviewed by certification specialists. One of the primary purposes of the case control reports is to provide RO management with information on those cases that are cleared and those that are still pending in the regional office.

- Case Control Reports

  As a result of your comments, the modifications to the case control reports which we expect will be programmed some time in August, are numerous and are described and illustrated in Attachment B. The most important change we incorporated into the reports was the formula for identifying cases that are still pending in the States. These recertifications, originally referred to as "cases overdue from SA", are renamed "cases for RO alert" and are based on type of provider. The criteria adopted for these reports are:

- General accredited Hospitals - cases that have a current survey date exceeding 36 months prior to the date of the report.

- All other non long-term care facilities - cases having a current survey date exceeding 15 months prior to the date of the report.

- Medicare, Medicare/Medicaid SNFs - cases whose time limited agreement (TLA) dates or extension dates are due to expire within 45 days of the date of the report.

- Medicaid only providers - cases whose TLA ending dates or extension dates are 30 days prior to the date of the report.

In addition, we have decided to modify Table 5 to identify those providers counted in case control Reports 1 and 2 as "cases for RO alert". The modified Table 5, generated biweekly, will then replace the proposed Report 4. As you can see, the existing MMACS scheduling tables 1 and 6 will probably need to be changed to conform with the modified Table 5. Also, Table 12 (Work Processing Times) could be changed to include additional steps. Before we proceed, we would appreciate your comments on modifying the tables.

If you have any questions or comments concerning any of this material, please contact Barbara Slobodin of my staff on FTS 934-7942.

Attachment

15

Skilled Nursing Facilities (L007 = 02, 03, 04) Provider Group 2

CRs	Data Tag	Identifier	Description
	F008	1A	Licensure
	F016	2A	Disclosure of Ownership
	F024	2D	Independent Medical Evaluation (Medical Review)
	F032	2F	Institutional Planning
	F033	2F1	Annual Operating Budget
	F034	2F-2	Capital Expenditure Plan
	F040	2F-4	Annual Review and Update
	F072	2K-6	Management of Personal Financial Affairs
	F073	2K-7	Free from Mental/Physical Abuse
	F081	2L	Patient Care Policies
	F082	2L	Policies Developed by Professionals
	F088	2L	Execution of Patient Care Policies
	F105	4B	Patient Supervision by Physician
	F122	4C	Availability of Physicians for Emergency Patient Care
	F124	5A	Director of Nursing Services
	F125	5A	Full-Time Registered Nurse Director
	F134	5C	24 Hour Nursing Service
	F135	5C	24 Hour Nursing Service
	F173	5E	Rehabilitative Nursing Care
	F181	5G	Administration of Drugs
	F189	5H	Conformance with Physician's Drug Orders
	F221	6B	Menus and Nutritional Adequacy
	F244	6G	Sanitary Conditions
	F272	8B	Control and Accountability
	F287	9A	Provision for Laboratory Services
	F296	9B	Blood and Blood Products
	F360	14 ~~15A~~	Patient Transfer
	F361	14 ~~15A~~	Written Agreement
	F362	14 ~~15A~~	Transfer of Patients Between Hospital and SNF
	F363	~~15A~~	Interchange of Information
	F364	~~15A~~	Security of Personal Effects
	F370	15B	Emergency Generator for Life Support System
	F395	15D	Communication System
	F435	16B	Aseptic and Isolation Techniques
	F449	17A	Disaster Plan
	F457	17B	Staff Training and Drills
	K9=B	15A	Life Safety Compliance
	L237=13	(RADARS Conversion)	
	L012#A, A1, B		Health and/or Life Safety Code Waivers

Critical Total - 38

Revised 05/23/85

Enclosure #2

STATE OF IDAHO
OFFICE OF THE ATTORNEY GENERAL

JIM JONES
ATTORNEY GENERAL

HEALTH AND WELFARE DIVISION
STATE OFFICE TOWER
650 W STATE 10TH FLOOR
BOISE, IDAHO 83720
TELEPHONE (208) 334-4006

June 26, 1985

Evelyn McChesney
Assistant Regional Attorney
Department of Health and Human Services
Region 10
2901 Third Avenue
Seattle, WA 98121

RE: Advice to Surveyors on Guidelines

Dear Ms. McChesney:

. In response to your request, I have reviewed and considered the document enclosed with your letter entitled, "Federal Interpretive Guidelines and Survey Procedures." Thank you for the opportunity to consider your offer to issue this document as joint state/federal advice; however, I must decline at this time.

Frankly, none of the three statements included in your document appear to amount to any sort of legal opinion as to the nature of federally issued guidelines. Rather, these statements look to be directions or suggestions as to the use of guidelines. The first two statements simply state that surveyors "should" use the guidelines. While I have no particular argument with such statements, they seem self evident and do not amount to legal advice or opinion. The meaning of the third statement is unclear to me. If what it means is that noncompliance with a requirement specified in the interpretive guidelines equals a violation of promulgated regulation requirements, I do not agree. Review of interpretive guidelines to which I have access seem to reveal some guideline requirements which are more stringent, specific or detailed than the actual promulgated regulation requirements. In those instances, the unpromulgated guideline requirements are unenforceable and their violation cannot, alone, constitute a violation of the promulgated regulations. Such guidelines, may be useful in indicating the intent of the regulation requirement, but are not enforceable in and of themselves.

More useful and, in my opinion, legally sound suggestions and directions regarding surveyor use of interpretive guidelines can be found in the recently issued State Operations Manual under section 2712, "Using the Interpretive Guidelines When Surveying". This section adequately points out that the guidelines cannot impose unpromulgated requirements on the public (even though, as mentioned above, some guidelines appear to attempt just that). Sub-part C of this section further explains that some latitude for surveyor judgment does exist and that some "guidelines" appear frankly as recommendations. Perhaps the guidelines referred to in this latter statement are the same ones that appear to exceed the requirements of the promulgated regulations. In any case, I find these directions in the State Operations Manual to be consistent with my own opinion. Perhaps you may reach the same conclusion.

I do appreciate your attempts to reach state and federal consensus on issues of joint concern. Hopefully, the channels of communication between our respective entities can continue to improve. Please do not hesitate to contact me with any further suggestions or questions.

Very truly yours,

Curt Fransen

Curt Fransen
Deputy Attorney General

2712. USING THE INTERPRETIVE GUIDELINES WHEN SURVEYING

Various appendices to this manual are entitled Interpretive Guidelines. These are intended to amplify the Conditions of Participation for specific types of providers and suppliers. You can take just the pertinent Appendix to the institution as an aid in completing the survey.

A. Content.—Some of the Interpretive Guidelines are arranged in 2-column or 3-column format. In these cases, column 1, "Standard," restates the Conditions of Participation or Coverage, which the providers or suppliers must meet. There are no additional or more stringent provider requirements in the other columns (because an agency cannot impose non-regulatory requirements on the public). Column 2, "Interpretive Guidelines," lists things the surveyor may find or observe that prove that each standard is met. Column 3, "Survey Procedures," contains both instructions and hints to the surveyor as to how to go about looking for, and how to collect and record the necessary evidence to prove that each standard is met. Often, elements in the standards are not repeated in Column 2 or 3 because these elements are self-explanatory. Therefore, the information in the three columns should be viewed and used together.

B. Interrelatedness of Standards.—There are numerous interrelated standards to be considered by the surveyor. For example, if medical records lack pre-surgical workup notes, do not merely fault the record system, but find out whether pre-surgical workups were actually consistently performed. This could reflect on whether medical staff or other standards are met. Where a standard requires the presence of a professionally qualified person, there is often a closely related standard which must be referred to to see what exact qualifications that person must have. For example, if a provider must have a pharmacist who is properly qualified, but does not, it will also fail a separate standard requiring participation by a pharmacist in reviewing medication orders. Thus, you must understand and apply the interpretive guidelines comprehensively.

C. Flexibility of Application.—There is some latitude for surveyor judgment, and some interpretive guidelines appear frankly as recommendations. For example, the specificity in guidelines for §405.1134(j)(3) that the heating system is capable of maintaining a comfortable temperature at least three feet above the floor does not necessitate noncompliance when the heat at a two-and-a-half foot level is comfortable. The measurement is simply an acceptable point at which the intent of the requirement may be judged. Other interpretive guidelines may recommend a minimal number of hours spent by an institution's professional consultants. Decide whether the time spent in the institution by the consultant is sufficient. A well-run dietetic service may require few hours of consultation, depending upon such factors as staff capabilities, training, and the cooperation of the administrator in instituting the consultant's recommendations. Conversely, if a poorly run dietetic service is observed, although consultation is frequent, do not check "met" simply because the minimum-hours recommendation is met. Prove whether the problem is in the quality of the consultation, failure to implement the consultant's recommendations, or some other cause.

KAREN RAHM
Secretary

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Olympia, Washington 98504

June 28, 1985

Ron L. Hansen, Director
Survey and Certification Program
Division of Health Standards & Quality
HCFA DHHS
Region X MS 409
2901 Third Avenue
Seattle, Washington 98121

Dear Mr. Hansen:

The Bureau of Nursing Home Affairs, having completed field testing and processing of the PaCS tool and survey method, has the following comments and recommendations.

Mike Jessup, Zone Manager who supervises the surveyors directly, has stated although it appropriately refocused the emphasis of staff and patient observation in the survey process, there is too much emphasis placed on the forms and papers rather than the methods used. The forms and checklists will not be beneficial for retrospective analysis. Reconstructing observations and factors which led to a met/not met decision will be difficult based on the forms and checklist information. The processing cost is more expensive due to increased time necessary to complete, review, copy, and send larger volume of paperwork through the mail.

Following the April 1, 1985 PaCS survey, an MSP survey at Crestview Moses Lake was performed April 8 and 9, 1985. Several elements were defined as not met. Without being aware of the PaCS findings an MSP survey was conducted by another team. Many of the same areas were cited but at a more serious level as seven standards were determined to be not met in nursing services, administrator, and infection control. The PaCS surveyor felt some of what was seen on the MSP survey was what she also had seen. But in following the PaCS guidelines strictly, a more thorough review to determine the depth of the problem was not required.

Gerry Bradshaw's analysis has been sent to Roger Monson and is also enclosed.

Important findings and recommendations that the Bureau wants to emphasize is that PaCS;

- does provide for more time for patient observation of care and service delivery than the traditional survey process,
- identified problems involving lack of appropriate supervision,

- does not measure the total performance of administrative management, unacceptable practice in Infection Control and Isolation, and restorative nursing programs.

- does not measure the "state of the art" and is fairly limited to basic level skills.

- Is bulky, repetitious, and not well designed for routine field work.

- drug pass procedure should be modified to better meet the intent for identifying hazardous practices which would have a direct effect on the patient.

- is not the best survey form to use for new providers or providers who are re-entering the program after decertification. Use of the traditional survey process would be a better assessment method.

It is commendable that HCFA is attempting a process with the primary focus on patient care services delivery outcomes. Consistency would be improved both federally and statewide. Having experienced the MSP/TSP comparison project, it was exceedingly apparent the TSP process in other states and at the federal level have been inconsistent in the determination of met and not met standards/conditions with excessive emphasis placed on paper compliance.

Thank you for making it possible to participate in the analysis of the PaCS field testing.

Sincerely,

Sharon L. Morrison

Sharon L. Morrison, Manager
Survey Program
Bureau of Nursing Home Affairs HB-11

SLM:kg

Enclosures: Mike Jessup memo, June 10, 1985;
Jerry Bradshaw [illegible] Analysis

cc: Conrad Thompson
Mike Jessup

Sharon

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XXXXXXX

RECEIVED
JUN 12 1985
DSHS BNHA
SURVEY PROGRAM

Roger Monson, R.N. June 10, 1985

FROM: Mike Jessup

SUBJECT REVIEW OF PaCS PILOT PROJECT

Attached is the surveyor questionnaire completed by Geraldine Bradshaw, R.N. following her field testing of the PaCS survey instrument and methodology. As you know, Gerry conducted a PaCS survey in 13 providers over a two and a half month period. I have read her evaluation of this field testing and concur with her findings. I would like to take this opportunity to add a few observations of my own regarding the proposed PaCS tool and methods.

Having processed these 13 PaCS surveys, it is readily apparent that far too much emphasis has been placed on the forms and papers, rather than on the methods used. The PaCS survey packet contains far too many forms, checklists, and other miscellaneous pieces of paper that are absolutely useless for retrospective analysis. These forms and check lists, when viewed after-the-fact, cannot be used by anyone (including the surveyor, in my judgement) to reconstruct the observations and factors which lead to a met/not met decision. As such, they would be useless in a hearing or other legal arena, and simply add unnecessary volume to the survey packet. They are time consuming to complete; time consuming to read, process, and copy; and extremely expensive to send through the mail. Besides which, because of their legal size, they can not be filed in our present system.

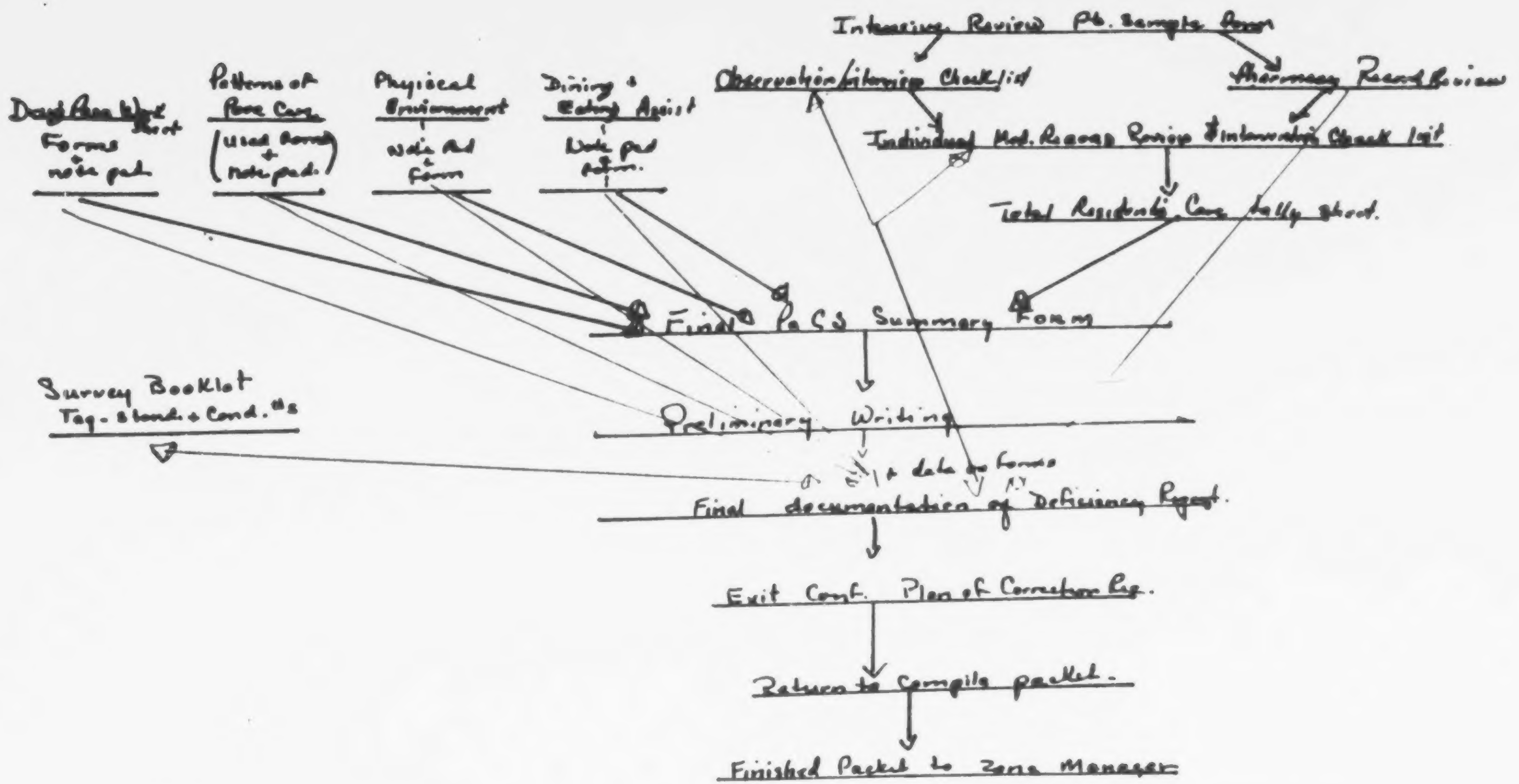
It is readily apparent to me that the Smith versus O'Hallaran decision has forced the issue to appropriately emphasize staff and patient observation in the survey process. As you are aware, this is not a change for the state of Washington, since we have been doing exactly that since 1976, using our Modified Survey Process. In our nine years of experience, we have learned that the key to successful, efficient surveying, which involves patient and staff observation, is not forms or tools, but rather highly skilled professional survey staff. It is my assessment that the skilled professional staff resident in the Survey Program in the Bureau of Nursing Home Affairs can "force" any survey system to work. They do this simply by being highly educated, highly trained, and capable of accurately assessing what they are observing, in light of the known intents of the regulations.

Conversely, surveyors who are not highly trained nor skillful at observing and assessing will not be able to be successful, no matter what kind of survey method or tools are used. It appears to me that the "cookbook" method of PaCS forms and checklists was developed to allow a basic entry-level surveyor to be "led by the hand" through the survey process at a purely generic level. In other words, the person will be guided where to look, will be told what to ask, and will be taken through the motions of the survey. This obviously is not enough. The surveyor needs to apply knowledge, logic, judgement, and assessment skills to arrive at appropriate compliance decisions. Beyond the scope of this current project, but still extremely important, is the issue of thoroughly documenting citations. PaCS does nothing to ensure that a well-written report is produced. Once again, it is the skill, knowledge, and training of the surveyor upon which we rely.

I am aware that not all states have nursing home surveyors of the quality found in the state of Washington. For some of those states, the PaCS survey method will probably be beneficial and progressive. That statement cannot be applied to the state of Washington. A question that comes to my mind is "Why dilute the effectiveness of the survey agency in the state of Washington and bring it down to a nationwide common-level of mediocrity?" Nationwide implementation of PaCS will ensure uniformity in all states. Unfortunately, for this state, it will be a step backwards to go to that level.

It appears that the development of PaCS, its nationwide testing and implementation, will be extremely costly. Once implemented, it will continue to be costly to states such as Washington, since it will not allow us to efficiently utilize our scarce surveyor resources to improve patient health and safety. It appears to me that the great deal of money spent on PaCS could be far better spent in adequately funding state survey agencies and requiring them to upgrade the quality of their survey staff by hiring highly educated, knowledgeable, and skilled surveyors and providing continuing training to fine-tune their skills. In this way, then, nationwide uniformity could also be maintained, but at a higher level of performance. If I had my choice, it would certainly appear to me that it is more beneficial to HCFA, the states, and especially the long term care clients, to be consistant at a high level of performance, rather than at a mediocre level.

c: Gerry Bradshaw
Sharon Morrison
John Stilz


Drug Pass Work Sheet
Forms + note pad
Patterns of Pass Care
(Used Forms + Note pad.)
Physical Environment
Note Pad + Form
Dining + Eating Assist
Note pad + Form.
Interview Review Pt. Sample Form
Observation/Interview Check list
Pharmacy Record Review
Individual Med. Record Review & Interview Check list
Total Resident's Care tally sheet.
Final PaCS Summary Form
Survey Booklet
Tag-Stand.+ Cond. #s
Preliminary Writing
+ data on forms
Final documentation of Deficiency Report.
Exit Conf. Plan of Correction Rq.
Return to Compile packet.
Finished Packet to Zone Manager.

Red lines denote back-tracking to material specifics required for deficiency statement content and complete tag identification. The [illegible] [illegible] is the need [illegible] from the [illegible] [illegible] [illegible] [illegible].

Surveyor Questionnaire

1. State Washington   2. Date 3 June '85

3. On average, how did your PaCS surveys compare to traditional surveys in the following areas?

	Traditional (average)		PaCS (average)
	TSO	M.S.P.	
Time (in hours)	(13)- 30.04	(13)- 30.57	(13)- 55.42 - (San. 20.0 + RN 35.42)
No. of surveyors	1 or 2	1 or 2	1 only
Disciplines (name)	R.N.-	R.N.	RN
	R.S.	R.S.	
	(Avg. taken - 1977)	(Avg. taken 1984)	(Avg. Spring 1985)

[20.0 Av. Avg. taken from San. input was 35.42 to R.N.

How much time were you allotted for each PaCS survey? as needed -

4. How much time did your first PaCS survey take?

47.0 Hours

5. After your first few surveys, was the time allotted sufficient to complete the PaCS survey? Time increased ē increase of assignment id est. working ē and ē a Sanitarian

☑ YES N/A   ☐ NO

How much time and how many surveyors would you recommend? Modifing the paper work + intake flow -

Recom. 30° - 32° RN Surveyors - to be complemented ē the Reg. Sanitarian.

What disciplines should be included on the team?

Nursing -
Sanitation

6. Were you able to see more residents (No) and spend more time (Yes) with them than on a traditional survey?

☒ YES   ☐ NO   ☐ SAME

Explain Even traditional survey work - I did make a 'round' - to see all pts - PaCS does give more time for patient observation + more appropiately time to actually observe cares + service deliv

7. Do you think the PaCS is more effective than the traditional survey as a means of assessing quality of care?

☒ YES   ☐ NO   ☐ SAME

Why? There is time to observe the delivery as well as assessment of the patient population needs ē responses to care delivery. This refers to 'quality' of care at bedside delivery - level.

8. What type of problems or attributes did you identify that you probably would have missed on a traditional survey?

Issues involving lack of appropriate supervision to assure techniques are safely - completely and compassionately delivered.
(Safety refers to physical well being as well as jeopard. due to inappropriate Infection Control issues etc.)

9. Were deficiencies easier to document under the PaCS?

☐ YES ☒ NO ☐ SAME

9a. What deficiencies were easier? Explain Sanitation issues were readily classified + easily stated -
Specifics of care plan in relation to Act & Social Services

9b. What deficiencies were harder? Explain Poor - unacceptable practice in Infection Control - Isolation. Specifics of care (individualized) not identified on forms - + realistic Nursing rehab programs -

10. Did you have difficulty grouping or aggregating individual findings, by resident, into overall findings? (Following Regs - Guide lines) -

☐ YES ☒ NO ☐ SAME

Explain No specific difficulty with grouping the data identified on forms.
Difficulty present in grouping findings from survey not identified in tickler sheet. Phrases #7

11. Do you think this tool is a fairer measure of facility performance?*
* Facility defined as entire operations.

☐ YES ☒ NO ☐ SAME

Why? This tool evaluates levels of quality of Care delivered + the services outcomes. This does not measure the total performance of Administrative management + skill development for the predictable future needs and internal action on 'utilization' of self audit reviews - (their own product + future care delivery

12. Do you think most surveyors would come to the same conclusions when using this tool?

☒ YES ☐ NO ☐ SAME

Why? The tool is fairly limited to basic level skills the issues presented are not the full "state-of-the-art" at this time. I feel a new surveyor - given an opportunity to work thru the system - would soon grasp the levels described + readily identify the data indicated. It est.: The forms set a "level" of expectation. Currently the "level" defined is overly basic in Nursing services for 'quality' of rehab programs.

13. Is there too much room for subjectivity or not enough?

☐ Too Subjective ☒ Too Rigid ☐ Just Right

Using a broad definition of subjectivity.

Explain

please see attachment

Are there specific areas where these comments apply?

Please see attachment.

14. Did you have problems understanding or applying any portions of the PaCS?

☒ YES ☐ NO

If Yes, what were the problems and in what areas did they occur?

Please see attachment.

15. Did you find any of the survey forms difficult to use? Which ones and why?

Please see attachment

16. How well does the Medical Record Review and Observed Intervention Checklist form work? Would you recommend any modifications or other methods to record this information?

Explain

Please see attachment

17. Did you have any difficulty summarizing findings on the total resident care tally sheet? Did the form help you to detect major problem areas? Do you have recommendations for modifying the form?

Please see attachment.

18. Did you have any difficulties following up on problems identified outside of the indepth sample for observation and record review?

Explain yes—

Please see attachment.

19. Did you find yourself periodically reverting to activities performed on traditional surveys? When and where? Partially – see attachment.

20. Do you feel that, once fully familiar with the PaCS survey, it would be no more difficult to conduct than the traditional survey?

☒ YES ☐ NO

Explain I believe the two survey processes can be conducted with no more difficulty or ease, one from the other. The significant factor is the perception of the surveyor to place the care delivery assessment in the proper perspective

21. Do the guidelines assist surveyors? Could they be improved or expanded? Explain

see attachment.

22. Was the triggering method adequate? Would you add or delete any triggering tag numbers? Explain

Please see attachment.

23. How would you change the PaCS? Where and why?

Please see attachment.

24. Do you think your PaCS training was adequate?

☒ YES ☐ NO

What would you change? Given a developed survey PaCS process the training should then be 'yes' or adequate.

First trial runs for most programs seldom if ever have preliminary training adequate to anticipate and circumvent all unforeseen issues in field use.

25. Other comments?

Please see attachment.

(If necessary, please continue your comments on the back of this page.)

12. The subjectivity of the surveyor is a crucial factor in identifying "quality" elements of care and services delivery being observed. Your definition and cautionary statements under "B Interview Guidelines" (page 19) are well taken. Subjectivity in quality assessments pertains to the judgement or evaluation of the facility staff and environmental outcomes observed in care delivery setting. In view of FaCS' intent to measure "quality" of care and services outcomes, subjectivity plays a key role. Specific areas where comments apply: (Comments refer to forms used during FaCS trial surveys.)

A. Observation/interview checklist:

1. Inadequate space to indicate the subjective evaluation of errors/omissions in observed care delivery, outcomes, and/or patient responses.
   a. Example in ADLs paragraph 1 column left. Six basic services listed with one box for indicator of poor technique. This is rigid as the deficiency could be in one to six areas and/or in multiples in between. We need to identify data that defines what was wrong in the observed care or in the delivery technique. This same rationale applies to all sections utilizing a small box for "other".
   b. Paragraph 4 column 1 versus column 2: Cross reference of F 178-180 in the deviations and "other" box. This area does not provide space for data entry. Granted, the evaluation space can be utilized when the intervention area is overcrowded. Looking at patients with multiple problems, the form becomes overcrowded, causing surveyor to depend on note pad for referenced data and clarity.

2. Specific discipline intake can be confusing and confining in present format. No clear definition for the overlap of services being provided by combined outside resources and nursing services. Example: When observing restorative rehabilitative services ordred and instituted by specialized Rehabilitation Therapists being followed in daily therapy follow-up by nursing services. There is no space to indicate what the problem identified actually involves for purpose of deficiency statement context.

3. Omission: Specific restorative programs used in quality care are not identified. Example: Bowel/bladder training section. No indication for the retraining programs. Data outlined is basically cares for incontinence. Such data could set an expectation or acceptance of care levels which do not support the quality of services needed for patients who may regain control. Another example is feeding

assistance, ADLs, and dietary sections. Each indicate feeding assistance needs. There is no indicator to indicate or identify a rehabilitative program activated for the levels of relearning self-feeding skills as indicated by individual needs. ADL section has no indicator for the support programs to teach and support the patient relearning self-help skills according to their individual loss needs.

B. Forms OMB number 0938-0400

1. Patient census data was incomplete to subjectively evaluate staff responses to identified programmed care needs. Refer to response at #18.

2. Patient safety factors not clearly identified on the form. Please see response at #18.

14. Problems applying portions of the PaCS are:

A. ADL scores and guidelines to its function.

1. Alphabet ranking of ADLs required time to resource the patient and health record, and evaluate the changes. More time in rating changes up/down is needed to determine if the findings might "indicate pervasive problems". It is indeed a rare health record which is not thinned at six month intervals. The data base for total scoring is available for very few. These were ranked and evaluated. The findings were not significant.

2. Surveyors are asked to establish the "quality" of care as being observed delivered at the time of the survey process. It is not realistic to guess at what may or may not have happened six months to a year ago. The variables are too numerous to detail here. The specific ranking data compiled was not used anywhere in compiling the survey report. The issue became a problem of time wasted. I suggest this be deleted and devote the time to observation of supervision effectiveness in ADL care support and delivery.

B. Resident Talley sheet.

1. Constant writing in for citable issues not identified on talley sheet. Lost time and increased surveyor frustration.

2. Numbers on the sheet are not necessarily good indicators for "quality" care being given nor the error being cited. Numbers do not define the actual deficiency (nor significance, depth of problem) versus indicating the category of service cited. The

surveyor must rely on the O/R intake and addendum notes taken to establish the context of the deficiency statements. The talley sheet is of no value in establishing the written report beyond grouping of findings numbers.

C. PaCS survey form

1. The form provides elemental and standard F number indicators in collection of survey deficiency findings to be cited. The form has no CFR condition numbers and standard indicators for report writing. This triggers the writer to leafing through another form to assure that the surveyor does not make the embarrassing and unpardonable mistake of writing citations under the wrong tag. Making suggestions--please see #23.

2. Triggers in the summary form come to the surveyors' attention at the time of total data collection for report writing. It would seem more valuable to see the "triggers" indicated earlier in the survey, the rationale being the surveyor could be alerted to a need for deeper research while in the process of data gathering. This would result in a more efficient use of time and timely availability of resource.

15. Problems with survey form 0938-0400 designed for intake data.

A. The first 12 pages collect data from the two rounds of facility, patient areas, and census data. There is no way the surveyor can identify data and record it on the appropriate pages while on walking tour. The constant flipping of pages back and forth is impossible to work with at that point. The outcome is note taking of what was seen where being entered in a sequence of time the issue was seen. Note taking sequence of happenings doesn't follow the category of the form data list. The end result is that the surveyor spends an evening's time to convert note data to the form. This is a duplication of effort which may be of value in the initial training to the PaCS survey process. This process rapidly wears thin for the surveyor utilizing this in a consistant, ongoing process.

B. The form does not to define a common interpretation of which elements to cite for given errors. This is most obvious in the sanitarian's section (pages 1-8). Such structured training obviously should produce higher degrees of consistency in surveyor documentation classifications.

C. Patterns of poor care are repetative and instruct the surveyors to use the observation/records form. Here is a specific example where we are asked to duplicate data from one form from notes without any further use of the data (pages 9-10).

D. Although the O/R forms are well used, there is no time in observation rounds of the patients to be fumbling the numerous legal-size sheets of paper locating the right page for the right patient, nor indicating significant data regarding observations of "another" patient. The outcome was the note pad again. Surveyor did experience minimal problem in attempting to use the interview sheets while interviewing. This distracted the patient beyond getting attention focused on the conversation and stimulated the roommate to interject helpfulness to the point of rendering the entire process a disaster. Scratched that one and tried again (without the forms).

E. Drug pass work sheets and pharmacy record reviews: No space or entry for omits or errors noted in reviews which may not be included in the 10 samples. Patterns of poor technique in established procedures have little to no room allotted for detail of deficiency (context) needed for inclusion in the citation report. No place to indicate improper storage problems, temperatures not in required ranges, and handling of drug supplies in unacceptable and timely manner.

16. Problems encountered with Record Review Data and Observed intervention checklist:

A. Some problems in entering specifics of data omissions for deficiency documentation needs. Example: The form does not define rehabilitative nursing programs. Bladder retraining is frequently used as an example. Where to enter the inadequacy of fluids for monitoring and intake levels? Humm. This is not a catheter care problem, not indicated in the given training section, hardly what you would reference in broad terms of inappropriate technique in rehab services, not necessarily a dehydration problem under nutrition at this time. There is no space to record the descriptive totals, even if you check intake deviations under the evaluation section. Outcome--surveyor frustration and return to the note pad.

B. Patients' rights have been "squeezed" in. There is not adequate space to detail a problem nor enter data. I suggest it be moved to page with tag numbers for the patients' rights. Better continuity and ample writing space is going unused.

C. Interview Intake Sheets: Two full pages for interviews were rarely used. Few alert, responsive residents are going to respond at any length. Most long term heavy care patients' conditions extremely limit their ability to respond for interview process. I recommend far less space be designated for this purpose. Open structured space would allow entry of data without trying to channel. The additional space could well be used in observational findings.

D. The Nursing Service column is limited. Realizing all the tubes and specialized equipments cannot be listed ad infinitum, suggestion: A small general heading entry identifying tube service needs, with open space for entry of data findings. The surveyor could fill in which specific equipment is used amd being evaluated. The benefits of the current itemized data intake direction could be re-established as a guideline to be used as needed.

E. General critique of interview resident/staff spaces: There are times when interviews are very timely and appropriate. There are frequently instances of the surveyor's being given an interview of well-rehearsed terms describing what they think the surveyor wants to hear, rather than the known and readily identifiable inadequate delivery explanation. The "quality" is still going to be the "proof of the pudding" which leaves the surveyor in the position of identifying such in the observation process. I do feel the space used up by the 11 boxes would make a more usable "other" area. The "other" area could well include such interviews that are conducted.

F. Data entry in current paper flow structure: Identifying a negative outcome in a multiple entry block leads to confusion and time loss tracking at time of drawing citation data together. Suggestions all through this critique have been for less structured and more open space for specific data entry. Surveyor can't seem to stress this point enough as it keeps reoccurring in evaluating where surveyor faced time delay and frustration in producing the statement of deficiencies.

G. F tag numbers on the O/R forms: I do feel the lists of F numbers are great for a training phase. The point was well taken at our training session in reference to surveyors developing a uniform use of F tags for similar or like citations. I suggest that a training time be considered, followed by retirement of the F tags to a guideline sheet. The rationale is that the unnecessary repetative exercise following training time would be eliminated, with a guideline support for any who prefer to use it as a resource. The benefits to the ongoing survey process is an increase in data entry space.

17. The tally sheet findings were frustrating in point of no classifications for some entries and the lost time

identifying this. Actually, the form did not help to detect the major problem areas, as problem areas were already established in observations and reinforced in the record data reviews and usual follow-up techniques. My personal opinion is that this form has been a waste of time. It may have merit as a training tool for new surveyors to visualize where data fits in to the appropriate tag numbers. My major concern is triggered from years of experience and the privilege of orienting new RN surveyors to survey field work. It has been more than one person who would predictably use the talley sheet number system as an indicator that numbers would trigger the standard's being not met. This decision would be a serious error and a jeopardy, as other numbers may well indicate a "low" reading when the deficiency justifies taking the standard out. All concerns aside, following are recommendations if the use of the talley sheet continues:

1. Include the expected Rehab Nursing Programs recognized in the current "state of the art".
2. Utilize the form as a training tool only.

18. Problems identified outside the O/R reviews:

A. Restorative nursing programs. The F175 tag is included. However, the observation lists do not include the data check for this level of observation. These programs are commonly used.

B. Patient safety and jeopardy:

1. Incident reports were verified. Abuse data was not appropriately followed up. There was no follow up on the predictable hazard to wandering patients in residence where access to hazardous areas is unguarded.

2. "Others" space is too small for data entry of drugs and prescription medicated treatment solutions left in patient areas. This practice creates a double bind as the patients are not protected by secured storage and the identifiable hazards of ingestion and/or self-injury if applied to eyes. The prescription is at risk to uncontrolled heat exposure and various opportunities for cross contamination. Although this practice was identified in the interview process as having been "approved", it is not acceptable (and was cited).

C. Infection control issues:

1. Use of improperly sanitized thermometers in patient care area: Would you believe the interview on this one ran "Nobody ever pointed that out to us..."? So much for trivia in what the surveyor is set up for on occasion.

2. Lack of hand washing and hand/uniform protection in soiled functions of direct care issues: (This practice was carried out by nursing and other personnel.) The form tends to indicate use in utility and facility environmental services. The specifics for this do not readily fit into the O/R form.

D. Patients' rights: Resident council is not identified anywhere. This is the most commonly used means for the residents to exercise their individual rights. There frequently are references in conversations with patients expressing their ability to pursue an issue of discontent in council. These patients are not comfortable nor do they pursue it independently.

19. I did find myself reverting to the Modified Survey Process (MSP) procedures the first three weeks. This action was more a reflex habit than any design to deviate from the assigned process. In the first three weeks much time was spent in re-reading the guideline material. It was difficult in some areas to convert thinking from MSP experience to following the PaCS. I did experience frustration through the entire process in regards to the rehab nursing programs. This issue may have been reinforced by the various DNS' reactions. Upon handing them a copy of the patient census form I did receive a reaction everywhere. Comments from the DNS' ranged from "Is this all? Where can I put the rest of the programs?" "I entered data on the tubes for you anyway..." Critique about lack of space for services to one comment of "I haven't seen this one in years." Their concerns and comments were noted here as a general reaction as to where the state of the art is. Making suggestion later for this issue. Although we do MSP surveys there have been times when a traditional survey is done. The process is not that difficult when the purpose is kept well in mind. It is obvious the two types of surveys are assessing health care delivery and services from different perspectives. Realistically, I can see where new surveyors may encounter some difficulty until they have the opportunity to field-test and gain experience in the two processes.

21. Guideline critique: The guidelines were of assistance in part. There were no clearly defined guidelines to establish the wide range of rehabilitative nursing programs. The "quality" of care is definitely influenced by the comprehensive assessments and care follow-up identified for rehab program needs. Although rehab programs are alluded to, the data is incomplete in the guidelines. The issue of ADL scores and their impact has been evaluated as a waste of time. Material was covered in the observation and review process--scoring not used for survey deficiency writing nor is it required in the regulations we survey.

There is a lack of follow-through in specialized care issues. Example: Tracheostomy care, the guidelines read much as the acute care setting services. I can not identify where the long term care team is invovlved with the patient assessment and evaluation if there is need for support services (such as speech pathology, possible need for OT and social service suport to bolster patients coping with reactions to loss of communication skill and altered body image repercussions).

I bring up this point of observation on the guidelines for rehab serves. The guidelines led your thinking to problems of the very basic (six) ADL level needs and the reconstruction of muscle/skeletal problems. What happened to the rest of the patient's needs? The guidelines need completion--identifiable in resourcing back some basic issues and coming up blank.

Social service guidelines index many common behavior reactions without touching on a very demanding, common, frustrating-to-staff members and time-consuming patient need--the behavior problems presented by the manipulative patient. This is so common and readily observable I'm surprised it missed the list.

Guidelines for record review of skin conditions fail to include the record documentation and incident report follow-up as necessary when bruises, wounds, and such injuries may be the result of patient change in condition, inadvertant repetitious self-injury, self-inflicted damage, and other issues which may involve others.

Bowel and bladder: Record review data is vague and generalized. A person new to long term care would have great difficulty in surveying the specifics for this one. It generalizes and alludes to at least four separate programs and their functions. The whole section is too vague. This point was again brought to my attention in the June 1985 issue of the American Journal of Nursing. This issue devoted several pages to the state of the art in long term care settings. The punch line came across loud, clear, and blue-inked, a two page spread headliner: "We went in thinking nursing home nurses were behind the times and not of high caliber. We learned the opposite. They are very talented. These nurses simply have a different focus." My point is, the concerns I have expressed are value-based on the individualized needs the long term care providers respond to and must be recognized in the evaluations of their outcomes and whole-hearted support of the drive to excell in their daily efforts.

Isolation procedures for care issues have no specific guidelines. The referenced material on page 10 is simplistic and incomplete. Dressing procedure does not include guidelines to follow, nor is the observable needs for this type of care services identified. If any area in nursing care should be closely reviewed for "quality", the handling and care of infections seems paramount to me.

22. Trigger number changes. Delete F82 through 88, standard on patient care policy. Rationale: The problems identified that relate to incomplete policy demonstrate/indicate a predictable need for a traditional survey. This standard is the accountability of administrative management and must be in functional condition for any and all care services/needs being admitted.

Addition of F131, accountability of the charge nurse supervision: The finest of policy, staff development, and designated care may well fail for lack of appropriate supervision and the guidance to redirect action to the proper delivery when the system may falter.

23. PaCS changes: The basic changes mentioned in this questionnaire relate to restructure of paper format for more meaningful input findings. The use of the forms are being suggested for training purposes. The bulk and repetition are not well designed for routine field work. In an effort to demonstrate the back-tracking to establish the report context data I have submitted a simple diagram.

Enclosed is a suggested approach to a "final" PaCS summary form. The intent is to incorporate the data you've defined in the format of the survey booklet including CFR headings and such data as we are required to identify on the HCFA 2567. The suggested booklet is designed to eliminate the back-tracking in the current approach.

The patient Census form provided is a tool to evaluate the nursing service department development of programs and care services to meet all patients' needs. This particular form enclosed has been field tested and does not conflict with standard requirements. The utilization has had a tremendous impact on nursing personnel in their efforts to seek out and achieve new methods and practices for the specifics of geriatric patient needs. Copies have been requested as a resource and reference guide used by charge level personnel in evaluation and assessments of their assigned patient population needs. In summary: The form sets an unspoken set of expectations for both facility personnel and surveyors to relate to.

25. Other comments: Drug pass procedure: Much time was spent in numbering and returning to the facilities for placing stickers prior to the pass watched. The use of the stickers did not provide any exceptional benefit. The stickers frequently were covered with hands and in some cases had fallen off. The review of the process identifies that the errors were primarily the actions of the medication nurse. The time and numbers had little to no

effect on the nurse performance. It is strongly suggested the use of pass evaluations, drop the use of stickers, and expand the acutal observations of nurses on shifts at times other than the first morning pass. The effect of a tough day, person not giving as many meds, relief personnel, and many other variables should be considered in evaluating the process. The intent as I see it is to identify any hazardous practice which would have a direct effect on the patient.

Having had the privilege to experience the PaCS process, there are several comments I would like to make. I suggest the revision of the final PaCS Summary Form with the rationale already entered. I strongly recommend that the enclosed Patient Census form be utilized as it is a bit more with the state of the art at this time.

I would like to recommend that the current approach and forms be considered as a training tool, perhaps the tool utilized for some 10 surveys to establish the tone of the communication or more common interpretation in citation writing practice. Then, following the initial introduction, the use of that tool with a packet designed with more appropriate entry spaces and the support data as a guideline reference.

To err is to be human, and he who has not procrastinated at some time is yet to be met. This is the basis for my recommendation of providing the vendors a PaCS survey annually (barring negative action needs) with a traditional survey routinely done every third year. It is my thought that if the facility that has, for whatever reason, developed problems in the administrative management level, it should have a review to correct the issue before the problem reaches the care delivery level. --A quality assurance review on a three year cycle.

Thank you.

Gerry Bradshaw

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

6325 Security Boulevard
Baltimore, MD 21207

July 1985

Effective Communication Increases Knowledge

and...

Knowledge can Improve a Surveyor's
Performance

which...

Ensures Quality Care to the
Medicare/Medicaid Beneficiaries

Dear Surveyor:

Over the past year, I have found it necessary to communicate directly with the "Front-Line Troops" of Survey and Certification, the State Surveyors. Therefore, I hope that this is the first of many letters I will share with you in the future. I think it is very important that you the State surveyors be aware of and involved with the many Federal and State activities and regulations that effect your jobs. I think that you can be more effective when you are kept abreast of the goings-on in HCFA.

Therefore, I would like to give you a "Birds-Eye" view of some of the activities and projects HCFA has underway which I hope will help you on the job.

Good Maintenance of Records and Procedures Does not always Ensure Good Quality Care.

Just because a provider maintains good By-Laws and has high credentialing requirements, it does not necessarily mean that its' patients receive good quality care.

PaCS

For several years we have been studying various modifications to the traditional survey process in long-term care facilities through Federally authorized demonstrations and State experiments in order to address this problem.

- In March we began a national test of a new survey instrument, THE PATIENT CARE AND SERVICES (PaCS) SURVEY PROCESS. As part of our evaluation of PaCS, regional office staff are conducting up to six Federal monitoring surveys in each State, resurveying the same facilities subjected to PaCS by the States. In three States, Connecticut, Rhode Island and Tennesse, the PaCS process will be evaluated through an experimental design of double blind studies in a representative sample of facilities. The New England Long-Term Care Center at Brown University is performing the data analysis for these States.

- As of June 20, we have completed 356 PaCS surveys throughout the United States.

Region I - 15
Region II - 23
Region III - 40
Region IV - 67
Region V - 89
Region VI - 30
Region VII - 18
Region VIII - 29
Region IX - 19
Region X - 26

We in HCFA have been extremely pleased with the cooperation provided by the States in adapting to this new process.

- Early feedback indicates that surveyors like the new process and are finding more deficiencies with this system than with the traditional survey process. However, two problems have been identified. Some States feel the process takes too long and others feel the survey form needs streamlining. We are working on these problems and hope to have a system that we can all use by January of 1986.

Ensure Compliance of Providers and Suppliers

- Facilities wishing to participate and receive reimbursement under the Medicare/Medicaid programs must meet certain basic eligibility requirements and conditions. The conditions are basically broad statements of what the law minimally requires a facility to meet to assure and protect the health and safety of patients and to maintain an adequate level and quality of care and services. Failure to meet a condition has always been a cause for terminating a provider's or supplier's program participation. We, in the Office of Survey and Certification (OSC), are undertaking several actions to ensure that poor providers are identified and, barring prompt remedial action, are eliminated from the program.

- I believe both State and Federal performance in this area has greatly improved over the last few years despite staffing shortages in State surveyor staffs and in Central and Regional offices. In FY 84, together we TERMINATED 865 facilities -- and approximately 78% of all facilities received complaint investigations and/or on-site follow-up surveys to insure that cited deficiencies were corrected. While our performance could be considered exceptional, we all know that there are still a lot of problems out there that need to be addressed and corrected.

Medicare/Medicaid Surveyor Training Program on the move

I firmly believe that a good training program is essential for State surveyors. OSC has initiated several projects to improve the quality of training for Medicare/Medicaid Surveyors.

For example, we are requesting outside consultants, who have the professional knowledge and skills in training, to assist us with our basic courses. We are looking for ways to improve our educational principles, design, faculty preparation and, selection of audio/visual techniques... etc.

This extra effort will provide a top quality Federal Training program for all surveyors.

Upcoming Medicare/Medicaid Training Courses FY 86

Date	Course	Location
October, 1985		
1-3	Psychiatric Hospital	Atlanta, Georgia
16-18	Home Health	Baltimore, Maryland
21-25	Basic Health Facility (Region IV surveyors only)	Nashville, Tennessee
24-Nov. 1	ICF/MR	Chicago, Illinois
November		
13-15	Psychiatric Hospital	Dallas, Texas
18-22	Basic Health Facility	Baltimore, Maryland

December		
2-6	Basic Life Safety Code	Baltimore, Maryland
10-11	Patient Care & Services (PaCS)	Baltimore, Maryland
10-12	Psychiatric Hospital	San Francisco, California
17-18	Patient Care & Services	Baltimore, Maryland

Nominations must be made through your Regional Training Administrator.

Questions Unanswered

We continually have surveyors ask us similar questions about several issues, regulations or surveying techniques in general. We will continue to answer these questions at our training sessions, through procedures in the regional offices and the State offices. However, I feel some questions are universal and can be answered in this manner.

Question: Can Medicaid Funds be disallowed for the cost of care of a few individual clients not receiving active treatment without decertifying the entire ICF/MR.

Answer: We have the authority to deny Federal Financial Participation (FFP) in the case of individual clients who are found not to be receiving active treatment by health surveyors.
This authority stems from the wording of the ICF/MR Statute (Section 1905 (d) of the ACT) which speaks to claiming only for individuals receiving active treatment. If your state survey agency does not have a copy of the recent Grant Appeals Board (GAB) decision in the Southbury Training School (Connecticut) case, it would be helpful to get one. The GAB upheld our authority to take individual FFP actions and our interpretation of what constitutes active treatment.

My overall message for all of us in HCFA and in the State agencies is to make sure we focus our resources on the provision of good quality of care. To carry out these goals, it is absolutely essential that we collaborate to provide maximum service to the people we serve. Remember, it is the service that counts, not the organizations we represent.

Sincerely,

Sharon Harris

Sharon Harris
Acting Director
Office of Survey and Certification

P.S. The entire FY 86 training schedule is now available in your State.

Enclosure #3

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health C
Financing Administration

Region X
M/S 409
2901 Third Avenue
Seattle, WA 98121

July 9, 1985

Jean Schoonover, R.N., Manager
Idaho Facility Standards Program
Department of Health and Welfare
442 West Washington
Boise, Idaho 83720

RECEIVED
JUL 12 1985
FACILITY STANDARDS
PROGRAM

Dear Ms. Schoonover:

We have not yet received a signed Section 1864 Agreement which is acceptable to the Secretary of the Department of Health and Human Services. Therefore, there is no assurance that your agency will be the agent responsible for Medicare survey and certification activities effective October 1, 1985.

Because of this situation I am directing that your agency immediately cease the following Medicare expenditures.

1. Equipment purchase orders which have not yet been placed. Included are office furniture and equipment such as desks, chairs, file cabinets, word processers and computer hardware and software.

2. Purchases utilizing any remaining monies in the ADP Contingency fund contained in the current fiscal year's budget.

3. Contracts for personal or other services which are not yet signed. Existing contracts which extend beyond September 30, 1985 shall be amended so as to not obligate Medicare funds past that date.

Your agency is expected to continue to fulfil the provisions of the Section 1864 Agreement which is currently in place. Included is the conduct of necessary surveys between now and September 30, 1985.

If you have any questions, please let me know.

Sincerely,

Thomas G. Wallner
Associate Regional Administrator
Division of Health Standards and Quality

cc: Bee Biggs
Roger Peratto

DEPARTMENT OF HEALTH & HUMAN SERVICES

Financing Administration

510

Region X
M/S 409
2901 Third Avenue
Seattle, WA 98121

July 9, 1985

Conrad A. Thompson, Director
Bureau of Nursing Home Affairs
Department of Social and Health Services
HB-11
623 - 8th Avenue SE
Olympia, Washington 98504

Dear Mr. Thompson:

We have not yet received a signed Section 1864 Agreement which is acceptable to the Secretary of the Department of Health and Human Services. Therefore, there is no assurance that your agency will be the agent responsible for Medicare survey and certification activities effective October 1, 1985.

Because of this situation I am directing that your agency immediately cease the following Medicare expenditures.

1. Equipment purchase orders which have not yet been placed. Included are office furniture and equipment such as desks, chairs, file cabinets, word processers and computer hardware and software.

   This cessation applies both to your regular FY 1985 funding as well as the WASH-SPIN Demonstration Project Funding.

2. Purchases utilizing any remaining monies in the ADP Contingency fund contained in the current fiscal year's budget.

3. Contracts for personal or other services which are not yet signed. Existing contracts which extend beyond September 30, 1985 shall be amended so as to not obligate Medicare funds past that date.

Your agency is expected to continue to fulfil the provisions of the Section 1864 Agreement which is currently in place. Included is the conduct of necessary surveys between now and September 30, 1985.

If you have any questions, please let me know.

Sincerely,

Thomas G. Wallner

Thomas G. Wallner
Associate Regional Administrator
Division of Health Standards and Quality

cc: Gerald Reilly
Ted Curcio

REGION X
FOUR-STATE L&C DIRECTORS
QUARTERLY MEETING
JULY 10, 1985
OLYMPIA, WASHINGTON

Participants:

Karen Martz
Maureen Whitman
Conrad Thompson
Sharon Morrison
Jean Schoonover
Eleanor Pedlow
Garlien Are'valo

Guests:

Jerry Reilly, Washington State
Medicaid Agency
Peggy Brown, Washington State
Deputy Attorney General

The quarterly meeting of the Region X Four-state Licensing and Certification Directors convened at 8:55 a.m. in the State Agency office building in Olympia, Washington. The minutes from the last meeting were approved.

Jean passed out page one of the nationwide L&C Directors list. This page had inadvertently been left off the list that was mailed to each director earlier.

Jean announced a workshop to be given by the Idaho Board of Pharmacy. This workshop will be held in September in Sun Valley, Idaho, and should be very informative. Anyone interested in the workshop should contact Jean for details.

At this time the group discussed changing the agenda. It was noted that the Regional Office was listed as responsible for several agenda items. Although the Regional Office did not choose to send a representative to this meeting, they have stated that they will be represented at the fall meeting. Jean and Conrad explained the history behind four-state meetings and R.O. representation to Karen and Maureen.

Training Coordinators Conference

The group discussed the July 23-25 Training Coordinators Conference which will be held in Baltimore. Concern was expressed that most training courses are held in Baltimore and that slots for Surveyor Training school are being given to providers, leaving insufficient slots for surveyors. It was agreed that these concerns will be brought up at the Training Coordinators Meeting and that each state would write the Training Committee.

Medication Pass

The problems encountered with the medication pass procedure were discussed. Idaho has never used the new medication pass procedure and Washington has been using it, but intends to stop. There was some confusion expressed about whether the states are required to follow this procedure or not.

Jean noted that not following State Agency letters, guidelines, procedures, etc., may someday result in audit exceptions. She explained the agreement between Evelyn McChesney, R.O. Attorney, and the Oregon State Agency to enforce interpretive guidelines. This agreement ensures that surveyors will enforce interpretive guidelines as regulation. The Regional Office is trying to get Idaho to sign the same agreement. The Deputy Attorney General from Idaho has sent a letter to the Regional Office saying that Idaho cannot enforce guidelines when they have not been promulgated as regulation.

Issue Paper on Federal Audits

Conrad is close to completing the issue paper on federal audits. The main concern seems to be the difference between 100% compliance and "substantial" compliance. It was agreed that Conrad would draft two letters for Jean to sign on this subject. One letter would be to the AHFLCD Board and one to Margaret Heckler. The letters will state concerns that the monetary penalty is unduly harsh and unreasonable, and that requirements seem to reflect calendar dates and not true compliance.

Institute of Medicine Study

The draft Institute of Medicine study was reportedly inadequate and the deadline for a final report has been extended six months.

Patient Care and Services (PaCS)

Several concerns were raised regarding the recent trial of the PaCS survey process. The outcome oriented process is good but the existing survey tool is inadequate. PaCS survey forms were cumbersome and time-consuming, and sanitation issues were not addressed.

It seems certain that some form of PaCS survey will be mandated. The four states expressed concern that new survey forms will be implemented without a chance for input from the states and that the process would be mandated before training is given. It was agreed that Jean would bring these concerns before the AHFLCD Board at the next meeting.

Federal Budget

Each state had received their federal budget letter. It was agreed to go ahead with budget requests as if the 1864 agreement is still in effect.

ICF/MR Issues

Jean explained the position R.O. is taking with Idaho on fire drills in small ICF/MR's. Idaho will be required to conduct fire drills on both the day and night shifts in each small ICF/MR and if one resident is incapable of getting out during the drill, decertification action for the whole facility must begin. Before Idaho begins doing these drills Jean will write a letter explaining the procedure to Legal Aid and the facilities involved. Washington has not conducted these fire drills but was recently told by R.O. that emphasis should be placed on ambulation, active treatment, and self-preservation, rather than fire drills. Washington is planning to do fire drills occasionally but not as a required part of the survey. Jean will ask R.O. to clarify whether or not the fire drill procedure is required.

Using the Fire Safety Evaluation System (FSES) in small ICF/MR's was discussed. Representatives from Central Office came to Washington and used the health care facility FSES requirements on a small ICF/MR. Idaho does not agree with bending the health care facility FSES requirements to fit small ICF/MR's. If the health care facility FSES requirements are used, exceptions for small ICF/MR's need to be added and authorized by the Feds. Fire safety surveyors will be meeting with R.O. representatives in late July to discuss this issue further.

AHFLCD Board Meeting

Jean asked the state representatives for items they wished to have reported to the AHFLCD Board. It was agreed that Jean would report on ICF/MR issues, surveyor training, and Oregon's new trusteeship laws.

Termination Procedures

The new termination procedures were not promulgated through the Administrative Procedures Act and this may present a problem in enforcing them. Updated information on these procedures should be received in the next few weeks.

Deeming of Facilities

There was nothing new to report on granting deemed status to facilities other than JCAH hospitals.

Four-State Regional Representative

Since the next meeting of the AHFLCD will be held in Madison, Wisconsin, the last part of this month. Jean suggested that the new four-state representative be chosen. Conrad accepted the nomination and Maureen agreed to serve as alternate.

1864 Agreement

Peggy Brown, Washington State Agency's Deputy Attorney General joined the group to discuss the status of the 1864 Agreement. Alaska has signed the agreement "as is." Washington, Oregon, and Idaho's attempt to sign an amended agreement was not acceptable. The R.O. has begun sanctioning states that have not signed the agreement. The options to signing or not signing the agreement were discussed at length. It was agreed that each state would write to their congressional delegation to exert some pressure to force negotiation. Also, Conrad agreed to set up a meeting with Joseph Anderson, legal counsel, and 4-state representatives, in the near future to discuss the 1864 agreement.

Psychiatric Hospital Surveys - SL#171

No new information was available on this topic.

Inspection of Care Proposed Regulations

The new Inspection of Care regulations are reported to be due in August. No further information was available.

Surveyor of the Year

The surveyor of the year for each state is:

John J. Nevins, Generalist - Idaho

R. Stan Soth, R.N. - Alaska

Geraldine Bradshaw, R.N. - Washington

Dorothy Rands, R.N. - Oregon

After much deliberation by the four Agency directors, Geraldine Bradshaw from Washington was chosen as Region X's Surveyor of the Year. As the four-state representative, Jean will write a letter to Ms. Bradshaw congratulating her on this achievement. She will also write to the other State nominees.

Next Meeting

The next meeting of the four-state L&C Directors was proposed to be during the week of October 14. A final date will be set later after Jean contacts Tom Wallner.

The meeting was adjourned at 3:30 p.m.

Jean Schoonover

Jean Schoonover, R.N.
Region X State Agency Representative

/de

OFFICE OF THE
ATTORNEY GENERAL

RECEIVED
JUL 22 1985
DSHS UNHA OB-31
Bureau Operations Section

July 17, 1985

REC ... ED
JUL 10 1985
DSHS OB-31
Bureau Nursing Home Affairs

CONFIDENTIAL

Ms. Ann T. Hunsaker
Deputy General Counsel
U.S. Dept. of Health and
Human Services
Room 5460
330 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Ms. Hunsaker:

As I discussed with you in our telephone conversation today, the states of Washington, Idaho, and Oregon each advised Region X of HCFA that they were ready to enter into a new "1864 Agreement," provided that an additional article, "Article XVI-Clarifications," was included in the agreement. Region X officials have indicated that they have no authority to negotiate changes in the proposed agreement. Unfortunately, Region X's inability to negotiate and failure to present the states' proposal to anyone who could negotiate appears to have reinforced the states' growing preception that HCFA is no longer interested in maintaining a spirit of partnership in its relationship with them.

I very much appreciate your willingness to review the article we have proposed. The states' major concerns, which are reflected in the article, are that the contract allows HCFA to unilaterally change and add requirements imposed upon them and subjects the states to the risk of heavy financial penalties for minor, technical violations of these changing requirements. The agreement is, in my judgment, extremely one-sided.

I am enclosing the 1864 Agreement as presented to Washington for signature; the additional article proposed by Washington, Idaho, and Oregon; and the relevant correspondence between the Secretary of Washington's Department of Social and Health Services and the Region X Administrator. Also enclosed is a

Ken Eikenberry Attorney General
Temple of [illegible] Olympia, Washington 98504-0521

letter from Thomas Wallner, Associate Regional Administrator, directing the State of Washington to "immediately cease" certain Medicare expenditures. I understand that Idaho and Oregon have received similar letters from Mr. Wallner.

Thank you for your time and your consideration of our concerns with the proposed 1864 Agreement. Since there is considerable pressure from both sides to resolve the concerns and enter into an agreement, I will be contacting you again within the next two weeks.

Very truly yours,

Peggy L. Brown

PEGGY L. BROWN
Assistant Attorney General

PLB:sh
Enclosures

cc: Conrad Thompson, Director
Bureau of Nursing Home Affairs
Gerald Reilly, Director
Division of Medical Assistance

Copies to: Conrad Thompson
~~Sharon Morrison~~
Garlien Are'valo
Sid Olson
Don Gary

routed 7/23/85 cc

ARTICLE XVI
CLARIFICATIONS

In order to avoid uncertainty and to ensure that certain provisions and terms of this Agreement are interpreted as the parties intend, it is further agreed by and between the parties that the following represents their mutual understanding and interpretation:

1. The imposition of any new requirements by the Secretary through general instructions authorized by this Agreement shall be conditioned upon the provision of adequate federal funding to meet any such requirements;

2. The Secretary shall not adopt through general instructions requirements that constitute rules under the federal Administrative Procedure Act (APA), 5 U.S.C. §§ 551, *et seq.*, and therefore are required to be adopted through APA rule-making procedures;

3. It shall always be "feasible and practicable" to provide the state with adequate lead time to respond to the Secretary's reporting requests under Article II-H;

4. Except in emergency circumstances, it shall be deemed "feasible and practicable" for the Secretary to request the state to participate in the development of general instructions, pursuant to Article III;

5. With respect to all requirements that the Secretary is herein authorized to impose unilaterally and with respect to all actions that the Secretary is authorized herein to take unilaterally, the Secretary shall act reasonably and give the state reasonable notice thereof;

6. In evaluating the state's performance pursuant to Article V, the Secretary shall find that the state has met a performance standard when the state has substantially complied with such performance standard;

7. The Secretary shall give the state reasonable notice of termination in the event that the Secretary terminates this Agreement pursuant to Article V-E or Article VIII-C. Also, the state has the right to appeal the Secretary's determination to terminate under these provisions.

8. In no event shall the Secretary take longer than 120 days to render a decision regarding a claim over $50,000 under Article XIV-E.

RECEIVED
JUL 25 1985
FACILITY STANDARDS
PROGRAM

STATE OF IDAHO
OFFICE OF THE ATTORNEY GENERAL

JIM JONES
ATTORNEY GENERAL

HEALTH AND WELFARE DIVISION
STATE OFFICE TOWER
450 W STATE 10TH FLOOR
BOISE, IDAHO 83720
TELEPHONE (208) 334-4006

July 24, 1985

Ann T. Hunsaker
Deputy General Counsel
Department of Health
and Human Services
330 Independence Avenue, S.W.
Room 5460
Washington, D.C. 20201

Dear Ms. Hunsaker:

Over the past few months, Idaho officials have attempted to negotiate a contract known as an 1864 Agreement with Region X of HCFA. Two other Region X states (Oregon and Washington) have made similar attempts. I understand that you have been contacted by Washington officials and I am writing to add my viewpoint to the concerns I imagine they expressed.

Without addressing specifics, I believe it is accurate to relate that Idaho views the federally "approved" 1864 Agreement as a dictate, rather than a contract or agreement. Idaho is concerned that the "agreement", as proposed by Region X, will further unbalance the already badly lopsided federal-state partnership in the program in question. The 1864 Agreement seemingly provides Region X with a continuing means of exercising arbitrary and unfettered control over the state.

Region X has failed to seriously address the state's concerns and, in my view, has employed objectionable tactics to put pressure on the states to enter the agreement. Such treatment seems to confirm the states' fears. For example, Region X recently referenced the unsigned 1864 Agreement and ordered Idaho to cease certain expenditures from the current fiscal year budget. These frozen funds do not appear to be related to the 1864 Agreement in question, which will not take effect until October 1, 1985. A copy of this directive, dated July 9, 1985, from Tom Wallner is enclosed. It is just these sorts of unbridled directives that Idaho fears will be continued under the 1864 Agreement.

Thank you for your time and concern with this issue. If I can provide additional perspective from Idaho's point of view, please feel free to call.

Very truly yours,

Curt Fransen

Curt Fransen
Deputy Attorney General

Enc.

cc: Ralph Carpenter
Bee Biggs
Jean Schoonover

DEPARTMENT OF HEALTH & HUMAN SERVICES

1AS/O

Memorandum

[illegible]

Date July 30, 1985

From Associate Regional Administrator
Division of Health Standards and Quality, HCFA, Region X

Subject State Failure to Conduct Annual Surveys of Long-Term Care Facilities -- Follow-up to June 10, 1985 Memorandum

To Thomas G. Morford, Duputy Director
Health Standards and Quality Bureau, HCFA

Attached is a copy of our June 10, 1985 memorandum. We will appreciate a report of the status of this issue. Thank you for your assistance.

Thomas G. Wallner

Attachment

June 10, 1983

No Record in CU

Associate Regional Administrator
Division of Health Standards and Quality, HCFA, Region X

State Failure to Conduct Annual Surveys of Long-Term Care Facilities

Thomas C. Morford, Deputy Director
Health Standards and Quality Bureau, HCFA

Attached is documentation regarding instructions to the State of Oregon regarding annual LTC surveys. This information is furnished in response to your request in a recent telephone conversation. My understanding is that policy is not yet formulated regarding appropriate action to be taken when a state fails to conduct annual LTC surveys. (About 35 Oregon LTC facilities did not receive an annual survey—the average interval is 18-20 months.)

I will appreciate any guidance you may be able to provide.

Thomas G. Wallner

Attachment

[Facsimile of HCFA document received in illegible condition.]

CHRONOLOGY

NOTICES TO STATE

Doc. No.	Date	Document	Highlight of Content/Issue
1	11/20/81	State Letter Issuance - DHSQ to State	Discontinue annual resurveys
2	6/07/83	Budget notice - DHSQ to State	Annual Inspections of LTC Required
3	8/09/83	State 10/83-9/4 budget request-State to DHSQ	Promises annual LTC inspections
4	9/09/83	Budget Approval - DHSQ to State	Approves FY 1984 (10/83 - 9/84) activity, adds funding for staffing needed
5	3/25/84	Evaluative Report - DHSQ to State	Cites staff shortage, work load shortfall
6	4/18/84	Response to Evaluative Report-State to DHSQ	LTC work load not addressed
7	3/05/84	Letter citing LTC shortfall - DHSQ to State	Gives data on shortfall, requests action
8	3/??/84*	Letter requesting budget clarification, FTEs needed - DHSQ to State	Requests budget/staff reallocation if FTEs short
9	?/1?/84*	Letter requesting resolution, gives resource numbers needed - DHSQ to State	State says no added staff; requests action plan
10	6/xx/84**	Report of meeting between State/DHSQ	Surveys not done; State promises all will be done
11	7/26/84	Budget revision, increased staffing funds - DHSQ to State	State not staffed up to budget and budget needs increase

*** [Illegible]**
**** [as in original]**

CHRONOLOGY

NOTICES TO STATE

Doc. No.	Date	Document	Highlight of Content/Issue
1	11/[illegible]/81	State Letter Issuance - DHSQ to State	Discontinue annual resurveys
2	6/07/83	Budget notice - DHSQ to State	Annual inspections of LTC required
3	8/31/83	State 10/83-9/84 budget request - State to DHSQ	Promises annual LTC inspections
4	9/[illegible]/83	Budget approval - DHSQ to State	Approves FY 1984 (10/83 - 9/84) activity, adds funding for staffing needed
5	3/25/84	Evaluative Report - DHSQ to State	Cites staff shortage, work load shortfall
6	4/13/84	Response to Evaluative Report - State to DHSQ	LTC work load not addressed
7	[illegible]/84	Letter citing LTC shortfall - DHSQ to State	Gives data on shortfall, requests action
8	[illegible]/84	Letter requesting budget clarification, FTEs needed - DHSQ to State	Requests budget/staff reallocation if FTEs short
9	6/13/84	Letter requesting resolution, gives resource numbers needed - DHSQ to State	State says no add'l. staff; requests action plan
10	6/xx/84	Report of meeting between State/DHSQ	Surveys not done; State promises all will be done
11	7/26/84	Budget revision, increases staffing funds - DHSQ to State	State not staffed up to budget and budget needs increase

STATE OF IDAHO
DEPARTMENT OF HEALTH AND WELFARE
DIVISION OF HEALTH, STATEHOUSE, BOISE, IDAHO 83720-9990

August 1, 1985

Thomas G. Walner
Associate Regional Administrator
Division of Health Standards and Quality
Health Care Financing Administration
Department of Health and Human Services
Region X
2901 Third Avenue, M/S 409
Seattle, WA 98121

YOUR LETTER OF JULY 9, 1985

We have your letter of July 9, 1985, to Mrs. Jean Schoonover directing this agency to cease certain expenditures of funds already allocated to this agency. I also recall your telephone call to me on this subject. We feel that the requirements dictated in your July 9 letter are arbitrary and present an objectionable tactic to pressure Idaho to enter into an unacceptable "agreement."

This agency has demonstrated to you and we now further confirm our intention of a good faith negotiation of the "Section 1864 Agreement." To date, this Department has had no success in obtaining any assurances of mutual agreement. Instead, the proposed 1864 Agreement seemingly will provide Region X with a continuing means of exercising what we feel are arbitrary and unfettered controls over the State of Idaho. We are maintaining a hope that a meeting with Joseph Anderson, Regional Administrator for the Health Care Financing Administration, will obtain some of the eight assurances that the Director of this Department proposed in Article XVI, "Clarifications," which she attached to the agreement as offered by Region X. As you know, the document was returned to Mrs. Bowman as unacceptable.

We also object to the attempt by Assistant Regional Attorney, Evelyn McChesney, to issue a joint state/federal advice document that would give legal support to using nonpromulgated guidelines as requirements. We continue to object to sudden policy changes and directives from Region X that change policies and procedures without notice or promulgation. We continue to stand on the legally sound suggestions and directions regarding surveyor use of interpretive guidelines in the recently issued State Operations Manual, Section 2712, "Using the Interpretive

Guidelines When Surveying." This section clearly points out that the guidelines cannot impose unpromulgated requirements on the public (even though some guidelines appear to attempt just that). Subpart C of Section 2712 further explains that some latitude for surveyor judgment does exist and that some "guidelines" appear, frankly, as recommendations.

In any case, with our relationship currently strained under the existing Section 1864 Agreement with Idaho, we will attempt to gain assurances from Joseph Anderson consistent with those cited in our proposed Article XVI. The current circumstance of "guess what Region X is changing now?" is intolerable; and although we believe the Idaho Facility Standards Program is the right organization to conduct federal certification surveys of health facilities and services, we must improve the relationship. I believe this can best be done through communication and adhering to promulgated regulations and agreed-upon guidelines.

Although we have completed testing proposed ADP hardware that was recommended by Region X for purchase by Idaho, we will not issue purchase orders until we are able to come to terms on a new Section 1864 Agreement.

Bee Biggs

Bee Biggs, R.N., Chief
Bureau of Vital Statistics, Standards, and
Local Health Services and
State Registrar

BB/gy/M1

cc: Rose Bowman, Director
Jean Schoonover, Program Manager
Ralph W. Carpenter, Division Administrator
Roger A. Perotto, Laboratory Improvement
Curt Fransen, Deputy Attorney General

~~JOHN SPELLMAN~~
~~Governor~~

KAREN RAHM
Secretary

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Olympia, Washington 98504

August 6, 1985

TO: Conrad Thompson, Director

THRU: Denny McKee DM
Sharon Morrison SM
Sid Olson S.O.

FROM: TR Tom Robinson, Training Coordinator

SUBJECT: PATIENT CARE AND SERVICES SURVEY (PACS) IMPLEMENTATION ON JANUARY 1, 1986

Information on PACS training obtained during the training coordinators' conference July 22 - 25, 1985, must be viewed with alarm. In the normal, logical course of events involving implementation of an entirely new and difficult procedure, all surveyor training must be completed in time to familiarize providers as well as become readily competent with the new instrument. The minimum time requirement for this is about three months in Washington. The Integrated Surveyor Training Program Schedule obtained at the conference schedules eight of the ten regions (including ours) for PACS training after the January 1986 date of PACS implementation. This is irrational! There is no better way to create utter chaos for the surveyors and for the providers.

Aside from the obvious, above, there are impacts on even more fundamental principles.

The stated intent was that HCFA will not train all 2,500 surveyors in the country in PACS. They will train 25 surveyors from each region. The remaining PACS training is to be done by a video tape training package (not yet developed) given presumably by the surveyors that attended the HCFA PACS workshop. There are two resounding impacts as consequences of this procedure.

1. The PACS vehicle is a totally new and different survey in procedure and documentation. The foregoing surveyor training procedure delegates authority to the states to train and certify surveyors to sign survey documents--authority heretofore held in reserve by HCFA.

Conrad Thompson
August 6, 198~~6~~[5]
Page Two

2. There is a significant schedule and budget impact when surveyors are removed from surveying to train and be trained. It is clearly impossible to quantify this impact without any knowledge of the PACS training package. However, completion of the mandatory number of surveys in 1986 will be unattainable in the State of Washington.

Finally, the PACS procedure was tested in several different states including Washington. Major deficiencies were identified (see BNHA letter of 6/28/85, to Ron Hansen, Region X.) The procedure is now being revised with direct input from surveyors. Will the revised vehicle have solved the identified problems? Create new problems? There is a distinct potential risk for the implementation of a defective survey instrument without another trial and test.

TR:w

cc: Mary Crosby

Association of Health Facility Licensure and Certification Directors

August 6, 1985

Margaret M. Heckler
Secretary of Health and Human Services
Washington DC 20201

Dear Secretary Heckler:

Thank you for this opportunity to bring to your attention a matter of major importance to the federal government and to the states. The federal government has historically worked cooperatively with the states as a partner in carrying out provider certification for the Medicaid and Medicare programs. This concept of a partnership is consistent with a broad reading of the federal statutes, case law and long-standing practice.

As you know, the states have statutory health care licensure requirements and a constitutional mandate with police powers to protect the public health and safety. Each state also has legal due process rights for contractors. In addition, the states share in the program and administrative costs of Medicaid. When one considers these factors and the states' valuable front line experience in administering state licensure and federal certification requirements, there is an obvious need for us to work cooperatively as partners to assure effective program requirements. Clearly, such cooperation best serves the interest of patients.

At a recent public meeting at which some Board members of this Association were present, a high ranking official with the Health Care Financing Administration (HCFA) stated that there is no longer a state-federal partnership. It was further stated that the federal government simply contracts with the states and the federal expectation is the states are bound to comply with whatever changes are dictated by the federal office, without the opportunity to review and comment. The official used the analogy of contracting to paint one's house. We are not painting houses. The state also has an ongoing financial and regulatory responsibility to those very same patients.

The states' licensure and certification directors are concerned, as recent federal actions appear inconsistent with a productive partnership. For example:

- HCFA unilaterally, through the State Operations Manual, mandated new termination procedures for nursing homes. The states, consumers and others had no knowledge of these new procedures until after the fact. Concerns expressed by the individual states, the Association and others resulted in the suspension of implementation of the new procedures. Since then, productive discussions with relevant parties have occurred and should lead to more effective procedures. The lesson is that productive partnership discussions can and must occur before major changes are imposed on the states which must implement and administer these changes in the field.

- Recent federal action regarding the Medicare 1864 Agreement is contrary to earlier commitments made by the HCFA central office, that the federal regional offices would be able to negotiate the terms of the agreement with the individual states. HCFA is now dictating the terms with no opportunity for negotiation, creating an adhesion contract. This does not follow the traditional give and take of contract development. Further, it is not consistent with a state/federal partnership and is likely to lead to increased litigation between the states and the federal government.

  It is particularly ironic that the preface to the proposed Medicare 1864 Agreement states, "The 1864 Agreements are instrumental in facilitating the partnership* between the Department of Health and Human Services and the states."

- At this time, HCFA is working with the Association and others on the Patient Care and Services (PaCS) survey instrument. We appreciate the implications of the Smith vs. O'Halloran case and the need to make the certification survey process more patient oriented. Certainly the court did not intend to preclude a sensible process for developing an effective survey instrument. It is critically important that we continue to work cooperatively to assure the effectiveness of PaCS. It is this tool, the survey instrument, from which all decisions are derived and defended. The instrument is a key factor in determining the efficiency and and effectiveness of the survey. We are concerned that PaCS may be implemented in an untimely manner without the benefit of a final evaluation of the revised PaCS format, without appropriate surveyor training and procedures, and without ongoing review and discussion with the states.

We can all agree the overall survey and certification system should benefit from the comments and recommendations of consumers, providers, state agencies and interested parties. Such participation will help enable us to fulfill our mutual goal. The Association remains firmly committed to working with you to strengthen our partnership and to establish the most effective system possible to monitor this nation's health care.

We look forward to hearing from you.

Sincerely,

Louis E. Remily, President

Deputy Director, Bureau of Quality Compliance
Division of Health
P.O. Box 309, Madison WI 53701

LER:jmb
cc: Senator David Durenberger, Chair, Subcommittee on Health
Rep. Henry Waxman, Chair, Subcommittee on Health & Environment
Senator John Heinz, Chair, Senate Special Committee on Aging
ASTHO (Thomas Vernon, M.D., Colorado)

---

*Emphasis added

The Administrator
Washington, D.C. 20201

AUG 7 1985

RECEIVED

AUG 12 1985

OFFICE OF [illegible]

Rose Bowman, Director
Department of Health and Welfare
Statehouse
Boise, Idaho 83720

Dear Ms. Bowman:

This is in reference to correspondence you received several months ago from our Seattle Regional Office regarding the Section 1864 Agreement. The updated version of the agreement was enclosed. It specifies the respective responsibilities of the Federal Government and each State in carrying out the survey and certification provisions of the Medicare program. The particulars of the document were revised to reflect the additional functions and responsibilities that were occasioned by the various Medicare amendments and regulatory changes that have occurred since 1975, when the document was last updated. The revised document also incorporates the applicable Federal Acquisition Regulations, published in 1984, which govern the terms and conditions of agreements of this nature.

Enclosed, for your convenience, is another copy of the updated agreement. It largely reflects the current Federal and State roles in the Medicare survey and certification program. The effective date will be October 1, 1985, so I encourage you to accept and forward the document as soon as possible.

I look forward to your prompt attention to this matter, and our continued relationship in ensuring the health and safety of Medicare beneficiaries.

Sincerely yours,

Carolyne K. Davis

Carolyne K. Davis, Ph. D.

Enclosure

[ASSOCIATION OF HEALTH FACILITIES LICENSURE & CERTIFICATION DIRECTORS]
Association of Health Facility Licensure and Certification Directors

7 August 1985

Mr. Philip Nathanson, Director
Health Standards & Quality Bureau
Health Care Financing Administration
~~1849 Gwynn Oak Avenue~~ 6325 Security Blvd
Baltimore, MD 21207 Mail Stop 2D2, Meadows East

Dear Mr. Nathanson:

At its meeting on 30-31 July, the Executive Board of this Association voted unanimously to oppose the implementation of PaCS scheduled for 1 January 1986. The action was taken despite the generally accepted belief that the new patient-oriented survey is superior to the current one. Board members believe the 1 January date is premature for the following reasons:

1. national implementation will occur prior to the final evaluation report from Brown University of the three state experiment;
2. interpretive guidelines will not be written and available to state agencies;
3. HSQB training of surveyors will not begin until mid December and is scheduled to continue through February; and
4. of the 2200 surveyors conducting long term care surveys, only 275 will be allowed to attend HSQB training sessions; the remainder must be trained by state survey agencies using training modules, which are as yet undesigned and not even scheduled for delivery until some unknown date after the PaCS implementation.

State survey agency directors are concerned that the presence of any one of the above would seriously affect the successful implementation of PaCS; the presence of all four guarantees disaster. These concerns were made known to Bureau personnel during the last meeting of the PaCS Task Force, but apparently to no avail.

We urge you to delay the implementation date by at least six months and proceed in a more orderly fashion. As usual, members of this Association, especially those on the PaCS Task Force, are eager to continue working with your staff and are available for further meetings or for telephone consultation.

Sincerely,

Louis E. Remily
President

cc: Sharon Harris, HCFA
Thomas Vernon, M.D., ASTHO [illegible]

STATE OF IDAHO
DEPARTMENT OF HEALTH AND WELFARE
FACILITY STANDARDS PROGRAM
420 West Washington Boise ID 83720-9990 (208) 334-4169

MEMORANDUM

DATE: August 9, 1985

TO: Karen Martz
Maureen Whitman
Conrad Thompson
John Gerth
Ken Lewis
Eleanor Pedlow

FROM: Jean Schoonover, R.N.

SUBJECT: Minutes to July 10 Four-State Directors' Meeting

Enclosed are the minutes to the July 10 meeting in Olympia. Also enclosed are copies of several pieces of corresondence between Idaho and federal representatives which may be of interest to you:

1. Letter to Tom Wallner from Bee Biggs.
2. Letter from Evelyn McChesney to Curt Fransen.
3. Letter from Curt Fransen to Evelyn McChesney.
4. Letter from Curt Fransen to Ann Hunsaker.

The Training Coordinators' meeting was held in Baltimore July 23-25, 1985. As Chairman of the Training Comittee for the Association of Health Facilities Licensing and Certification Directors (AHFLCD), I attended and presented some views on behalf of the Association. Those items we discussed in Olympia were included. The federal position remains adamant regarding the Basic Surveyor Training Courses being held in Baltimore; the allowance for providers to attend the training courses when slots are available; and, full implementation of PaCS January 1 without provision for adequate surveyor training prior to implementation. This position was reinforced at the AHFLCD Board Meeting the following week.

July 30-31, 1985, I attended the AHFLCD Board Meeting in Madison, Wisconsin. Mintues to this meeting will be sent to you as soon as I receive a copy. A few brief comments:

1. Thirteen (13) states have not signed the 1864 Agreement to date (Washington, Idaho, and Oregon included).

2. Termination Procedures are expected out shortly without going through the APA process.

3. Attorneys for the plaintiffs in Smith vs. Heckler (formerly O'Halloran) case have rejected implementation of PaCS as a solution to the problem of HCFA assuring quality of care in nursing homes. A hearing is expected regarding this in September. Sharon Harris announced that the rejection would not deter full implementation of PaCS on January 1, 1986. The AHFLCD Board is filing objection to the January 1 implementation date.

4. HCFA position remains adamant against surveyors providing consultation during the survey of a facility. Emphasis is on enforcement.

5. Inconsistencies between federal regions continues regarding interpretation of regulations and procedures.

Times are changing in HCFA. Directions are confusing and frustrating not only for the states but regional offices also. I'm sure we will all survive it despite the painful steps getting there.

Next Region X Directors' Meeting. I received a response to my letter to Tom Wallner regarding the next meeting proposed for the week of October 14, 1985. Mr. Wallner informed me that a meeting would be held and that late October or November would be best for them "due to the press of beginning federal fiscal year business in early October." He said he would contact me to establish a mutually agreeable date. I will keep you informed.

The Annual AHFLCD meeting is scheduled to begin Tuesday, November 12 and end at noon on Friday, November 15. It will be held in Philadelphia, Pennsylvania. Further information will be forwarded to you when I receive it. I hope all of you can attend.

JS/nh

Enclosures [COMMITTEE STAFF NOTE: Please see July 10 meeting minutes elsewhere in this chronology of correspondance.]

file copy
Bureau Admin office
(Janette Lytle)

STATE OF IDAHO
DEPARTMENT OF HEALTH AND WELFARE
STATEHOUSE
BOISE, IDAHO 83720-9990

August 14, 1985

Carolyne K. Davis, Ph.D.
Office of the Administrator
Health Care Financing Administration
Department of Health & Human Services
Washington, D.C. 20201

C. McClain Haddow
acting HCFA admin.

Dear Ms. Davis:

On August 12, 1985, I received your letter concerning the "updated" Section 1864 Agreement. The "updated" version is identical to the one we received in February of this year from Joseph Anderson, Regional Administrator, Region X, Health Care Financing Administration office.

As you may be aware, Idaho has attempted on two occasions to negotiate changes with Region X in the Agreement which would more clearly reflect mutual responsibilities. We have been informed that negotiations are not permitted by the Health Care Financing Administration and therefore we and representatives from Oregon and Washington plan to meet with Mr. Anderson on August 23. At the meeting, it is anticipated that some assurances regarding the contract can be reached which will make the signing of the Agreement more acceptable to the three states.

Based upon the outcome of the meeting with Mr. Anderson and Idaho's good faith effort to comply with the conditions of the new Agreement, we expect to sign the Agreement prior to the effective date of October 1, 1985.

Sincerely,

ROSE BOWMAN
Director

RB/nh

cc: Ralph W. Carpenter, Administrator, Division of Health
Joseph E. Anderson
Thomas G. Wallner

DEPARTMENT OF HEALTH & HUMAN SERVICES
Office of the Secretary
Washington, D.C. 20201

August 16, 1985

MEMORANDUM TO THE SECRETARY

FROM: The Under Secretary

RE : Initiative on Nursing Home Discrimination

To address the issue of nursing home discrimination, we established an HHS Working Group composed of representatives of HCFA, AoA, OCR, OIG, OGC, and OS/ES to look into the matter. The Working Group has held numerous meetings, examined available data on complaints of discrimination to determine the extent of the problem, and has developed the action plan set forth below.

The Problem

Based on the Working Group's investigations, which included the examination of complaint data on file with HCFA, OCR, OIG, Regional Offices and information obtained from State agencies, there is reason to believe that some nursing homes are illegally discriminating against Medicaid-eligible people - the major claim being on the basis of the "method-of-pay" (Medicaid vs. private-pay). In particular, there have been complaints that some nursing homes make admission or retention of Medicaid-eligible patients conditional upon payment of sums over and above Medicaid reimbursements; that some homes require patient adherence to private-pay contracts beyond the point at which patients become Medicaid-eligible; and, that some deny admission on the basis of handicap, such as in cases where the applicants require heavy care. Racial discrimination has also been charged as a basis for admission denial. These types of actions constitute violations of existing Federal and state laws and it is clear that effective measures must be taken to stop such actions.

Although it is apparent that illegal discrimination is a problem which must be dealt with in a coordinated, effective manner, it is also apparent that the extent of the problem is unknown because of a scarcity of available evidence. While the Senate Special Committee on Aging, which has held hearings chaired by Senator John Heinz, has indicated that illegal discriminatory practices by nursing homes are widespread, to date, HHS has not received hard evidence to establish the extent of such practices. Indeed, the Working Group has found only a relatively few recorded complaints of discrimination. The Department of Health and Human Services will certainly take action commensurate with scope of the problem, and those who would exploit and violate the rights of the elderly for profit must be prosecuted to the fullest extent of the law. However, in order to deal with the problem in the most effective and efficient manner we must determine its true scope.

Actions To Be Taken

The Working Group has developed a three pronged approach to deal with illegal discrimination in nursing homes which includes: (1) An educational program to inform the public (including consumers and the industry), State agencies and operational divisions (OPDIVs) within HHS, about the types of practices that are prohibited by law; (2) coordinated enforcement of existing discrimination laws; and, (3) coordinated data collection efforts among HCFA, OIG, OCR and State Medicaid agencies (including Ombudsman) to monitor and identify the scope of illegal practices.

Discussion

Since the Working Group was formed in November, 1984, its members and their respective organizations within HHS have worked to define the nature of the problem; determine which laws can be used in the fight against illegal discrimination; gathered available data on the extent of the problem; and, considered various approaches to effectively combat the problem. Simultaneously, the Working Group and the respective OPDIVS represented on the Group undertook interim steps to stop illegal discrimination in nursing homes.

Early on, the Working Group recognized the need to identify existing Federal law applicable to discrimination complaints. This need was underscored by the realization that there were misinterpretations and misunderstandings by many people in and out of the government as to what laws were applicable to the various types of conduct being complained about. Accordingly, the Working Group requested OGC to prepare a detailed analysis of legal authorities relevant to the issue of nursing home discrimination. A copy of that analysis is attached as Attachment I. Several of the more important Federal laws include Section 1909(d) of the Social Security Act, which is a criminal statute (enforced through the various U.S. Attorneys offices) that prohibits nursing homes from charging any consideration from a Medicaid-eligible person beyond Medicaid reimbursement; and, Title VI of the Civil Rights Act of 1964, along with Section 504 of the Rehabilitation Act of 1973, which prohibit discrimination on the basis of race and handicap, respectively. The other applicable Federal laws are described in Attachment I.

In late November 1984, AoA conducted a nationwide Ombudsman Training Conference in Philadelphia, Pennsylvania. Representatives from OIG participated in the conference along with several members of the Working Group. This conference provided an excellent opportunity for HHS to educate the State Ombudsmen about anti-discrimination authorities. Specifically, OIG discussed the provisions of Section 1909(d) of the Act and what the Ombudsmen should do when suspected violations are identified at the State level. State attendees were provided with a list of OIG Regional Inspectors General and urged to seek assistance from the regions in connection with any potential violations that arise. State officials were also urged to pursue prosecution under applicable State laws and to seek the adoption of State laws to parallel Section 1909(d). An important aspect of the presentation was a discussion of Section 504 and the type of access denials considered to be violative of the law. In addition, the conference resulted in a valuable exchange of suggestions and ideas. For example, a number of participants suggested that it would be desirable for both HCFA and the OIG Regional Offices to work with and assist the AoA Regional Offices in providing information and training to the State Ombudsman program people on a local level.

Following the Ombudsman Conference, OIG issued a memorandum to its Regional Inspector's General advising them of an anticipated increase in the number of Section 1909(d) complaints and provided uniform interpretations of what types of conduct by nursing homes constitute a violation of Section 1909(d). OCR also discussed the issue with its Regional Offices and is planning to include the issue in future nursing home compliance reviews.

The operating divisions represented on the Working Group (HCFA, AoA, OCR and OIG) examined complaint files and contacted their Regional Offices and relevant State agencies to ascertain the nature and extent of discrimination complaints received by the Department. However, those efforts revealed relatively few complaints. In particular, OPDIV reports to the Working Group included:

- HCFA - Conducted an informal survey of its headquarters, regional offices, and State agencies which revealed few complaints against nursing homes and those few concerned quality of care rather than access.

- OCR - OCR receives complaints through its regional offices, through referrals from advocacy groups, as a result of compliance reviews, and from State civil rights offices. OCR received 245 complaints of all kinds against nursing homes in a recent three year period. Most concerned employment. OCR is aware of only five complaints dealing with access. All five were 504 complaints involving heavy care patients.

- AoA - The most recent compilation of Ombudsmen reports is for FY 1982. State Ombudsmen are not required to use standard reporting categories which include access issues. However, five States voluntarily used an AoA-recommended format which does encompass access issues. Out of a five-State total of approximately 2500 complaints, seven complaints were categorized as "Admission refused due to Medicaid status," six were "Transfers due to Medicaid status," five were "Medicaid discrimination other than admission or transfer," three were religious discrimination, and three were race discrimination.

- OIG - In November of 1984, OIG reported approximately 23 Section 1909(d) cases pending in OIG or in the States, nearly half of which were in Massachusetts. In addition, during the course of the Working Groups' deliberations a small number of complaints were referred to the Inspector General who, in turn, forwarded the complaints to the United States Attorneys for the respective jurisdictions involved. In many instances, however, U.S. Attorneys have not prosecuted those case due to the small dollar amounts involved and the relatively minor nature of the cases from their perspective. It is believed that some States may be taking on the prosecution of these types of complaints under comparable state laws. On a more encouraging note, some six complaints involving nursing homes in the Eastern District of Michigan have been referred by OIG to the U.S. Attorney in that district and it is believed that the U.S. Attorney will prosecute these complaints.

There are several possible explanations for the small number of complaints including: Victims of nursing home discrimination are unaware of the laws against illegal discrimination; applicants who are denied nursing home admission or who are pressured into making payments in excess of Medicaid reimbursement levels typically find themselves in a situation where they must make immediate arrangements and, thus, do not bother registering complaints because they cannot wait long enough for their claims to be resolved; potential Section 504 complainants may not equate their conditions with a handicapping condition subject to Section 504 jurisdiction; and/or there may be an insufficient record and central reporting mechanism within HHS and the State Medicaid agencies to track the problem. It is also possible that discrimination is simply not a widespread problem.

During the course of the Working Group deliberations it was determined that while the Department has a number of legal authorities which can be used to address various aspects of the problem, the lack of coordination among HHS components has reduced the Department's effectiveness in dealing with complaints. In order to address this concern, the Working Group has recommended that a single coordination mechanism be established. To ensure that such a mechanism be established forthwith, without cumbersome changes in current lines of authority or responsibilities within the Department, that the Working Group will stay in existence and be charged with the responsibility of coordinating the initiative on nursing home discrimination. In light of the fact that the operating divisions charged with administering the programs that deal with nursing homes are already represented on the Working Group, this recommendation is entirely logical. Moreover, it will assure continuity of responsibility and demonstrate the Department's continuing commitment on the issue.

The Working Group will meet on a regular basis, perhaps on a monthly or quarterly basis, at which times the members will review individual OPDIVS' efforts to implement the Secretary's initiative; share information and experiences encountered during the preceding period; and, recommend adjustments or changes to the Secretary's initiative, as they deem necessary.

Regional Directors of HHS will be responsible for coordinating the initiative in their respective regions. Their responsibilities will include such things as ensuring that information obtained by one OPDIV in a particular region is shared with the other OPDIVS in the region. In short, the Regional Directors will be the focal point for cooperative and coordinated efforts by the OPDIVS at the regional level. Further, the Regional Directors will be expected to participate in the educational efforts as part of their regular outreach responsibilities (i.e., public speeches and other informations duties).

The Deputy Under Secretary for Intergovernmental Affairs, who already has line responsibility over the Regional Directors, will be charged with the responsibility of overseeing the efforts of the Regional Directors and he will be included as a new member of the Working Group.

This action plan is designed to enhance, not change, the existing operating responsibilities of the individual OPDIVS in combating illegal discriminatory practices found in the nursing industry. Specific complaints of Section 1909(d) violations will continue to be referred by HCFA to OIG. HCFA will retain the responsibility for assuring that State agencies require nursing homes to comply with the provisions of Section 1916 of the Social Security Act, which prohibits charges by nursing homes in excess of Medicaid reimbursement. Enforcement of Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act will stay within the purview of OCR. And, with improved coordination and information sharing between HHS agencies we believe that enforcement efforts will be improved.

Specific Actions

1. Notices and letters clearly explaining all legal requirements, prohibitions, sanctions, and remedies relevant to nursing home access will be sent by HCFA to all nursing homes with Medicaid-certified beds, elderly Medicaid recipients, consumer and industry groups, Regional HHS Offices, State Medicaid agencies, Ombudsmen and State Medicaid Fraud Control Units. In addition, special notices will be sent by OCR to the 500-600 certified nursing homes nationwide which have received Hill-Burton loans, loan guarantees, or grants, explaining their obligation under Hill-Burton requirements not to discriminate on the basis of method-of-payment, i.e., that they may not give preference to private pay patients. Finally, conferences and training sessions will be planned to coincide with dissemination of the notices.

The members of the Working Group believe that this measure will be extremely effective, particularly since there is good reason to believe that many suspected violations may be due to ignorance of the law rather than a conscious effort to deny the rights of Medicaid-eligible people. In this regard, several examples were cited in the Senate hearings of nursing home contracts actually containing written clauses in direct violation of Section 1909(d). Inclusion of such clauses in writing suggests that the nursing homes involved were unaware that they were violating a criminal statute that carries a maximum $25,000 penalty. Informal surveys of regional and State officials and Ombudsmen also indicate ignorance of the legal requirements relating to access to nursing homes. The dissemination of thorough and carefully worded notices, we believe, should go a long way toward eliminating this ignorance and result in voluntary corrective actions by many of the homes that have been out of compliance with the law. Moreover, notices can be sent quickly and attract sufficient attention in the press and media to result in maximum educational value to all interested parties.

2. In order to ensure that all complaints of nursing home discrimination are appropriately recorded, two steps will be taken.

   First, all Regional Offices of relevant HHS agencies will be asked to make periodic reports on the substance and quantity of complaints received.

   Second, State Medicaid agencies and Ombudsmen will be asked to report on the number of complaints received in a given period which fall into specific categories relevant to nursing home discrimination issues. In most circumstances, a request for such information must receive the approval of OMB, often a long and difficult process. However, if the information is requested from nine or fewer entities, OMB approval is not necessary. Thus, we could choose nine States to which we would send requests for reports of complaints falling into precise categories relevant to our inquiry. (ASMB cautions that if we send such requests, however, we should state explicitly on the requests that they are being sent to no more than nine entities, and we must try to avoid duplication of OMB-approved reporting. Such requests most likely would not be considered duplicative of current AoA Ombudsmen Surveys, according to ASMB.) While proceeding with circulation of our information requests to nine entities, we could simultaneously seek approval from OMB for a broader promulgation of our questionnaire.

3. The OIG has reported that there has never been a Section 1909(d) prosecution despite efforts to persuade various U.S. Attorneys to do so. Even a single prosecution, such as is being sought in the Eastern District of Michigan, would be highly effective in persuading nursing homes of the

Department's resolve to pursue violators. If U.S. Attorneys in the various States do not move forward on these cases, HHS should communicate with the Justice Department at a higher level to bring about prosecution. The Department should also continue to encourage those States that do not presently have provisions comparable to Section 1909(d) to enact such statutes.

In those instances where denial of nursing home admission to "heavy care" patients is deemed to be in violation of Section 504 of the Rehabilitation Act of 1973 (discrimination on the basis of handicap) prosecution should be vigorously pursued. Further, OCR could increase its outreach efforts to nursing homes, industry associations, and senior citizen groups. OCR can also conduct project reviews (in which questionnaires are utilized) and compliance reviews (including site visits) of nursing homes which are suspected of discriminatory practices. Assessment of performance in this area should become part of routine reviews.

The other legal weapons cited in Attachment I should be also vigorously pursued as appropriate.

4. In order to obtain maximum coordination of efforts in combating illegal discrimination by nursing homes in the shortest period of time, the Working Group, consisting of high level representatives from HCFA, AoA, OCR, OGC, OIG, OS/ES and the Deputy Under Secretary for Intergovernmental Affairs (DUSIGA), will remain in existence and meet on a regular basis (quarterly or monthly). The Working Group's charge will be with the overall responsibility for coordinating the anti-discrimination initiative; monitoring the activities of the individual OPDIVS; serving as a high level focal point within HHS for the sharing of information obtained by the individual OPDIVS; and, recommending adjustments to the initiative, as necessary.

5. In addition to recommendation number 4, the Regional Directors of HHS will be responible for pressing the anti-discrimination initiatives in the areas of enforcement, dissemination of information and information gathering by HCFA, OCR, AoA, Public Affairs, OIG, and others. The Regional Directors will report to DUSIGA, who already has line authority over them, and the Deputy Under Secretary will participate as an active member of the Working Group.

cc: Chief of Staff
ASMB
ASPE

HHS Working Group on
Nursing Home Discrimination

DUSIGA
HCFA
AoA
OCR

OIG
OGC
OS/ES

Attachment I

HHS LEGAL AUTHORITIES

Section 1902(a) of the Social Security Act requires that a Medicaid State plan "must provide for payment...of rates...which...are reasonable and adequate...to assure that individuals eligible for medical assistance have reasonable access...to inpatient hospital services (including services in skilled nursing and intermediate care facilities) of adequate quality." This requirement has been interpreted by the courts to allow broad State and Federal discretion in setting payment rates.

Section 1909(d) prohibits nursing homes from charging or accepting money or other consideration beyond Medicaid reimbursement for any Medicaid-eligible person as a condition of admission or continued stay. This is a criminal statute, enforceable by the Department of Justice. There has never been a Federal 1909(d) prosecution. Some States have statutes similar to 1909(d) and there have been some State prosecutions.

Section 1916 also forbids acceptance of consideration beyond Medicaid reimbursement. This statute is primarily enforceable by State agencies, which may decertify a nursing home for violation. It is secondarily enforceable by HHS, which may withhold Federal funds from a State agency for allowing violation. Federal funding has never been withheld on this basis.

In order for a State to receive funds from the Administration on Aging, it is required by 42 USC 3027 to have an ombudsman with access to long-term care facilities and patient records, and to establish a uniform State-wide reporting system on complaints and conditions in long-term care facilities.

Section 504 of the Rehabilitation Act of 1973 which prohibits discrimination on the basis of handicap, might be applicable in cases where certain heavy care patients are denied admission. Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race.

Regulations implementing Section 1621(b) of the Public Health Service Act prohibit discrimination on the basis of method of payment in nursing homes which have received Hill-Burton loans, loan guarantees, or grants. Only approximately 500 homes, out of a total of 18,000 certified nursing homes, have received Hill-Burton assistance are not subject to these provisions which require admission and treatment regardless of ability to pay or source of payment.

Conditions of participation for skilled nursing facilities and intermediate care facilities include standards at 42 CFR 405.1121(k)(4) and 42 CFR 442.311(c), respectively, which prohibit transferring or discharging a patient except for medical reasons, for his welfare or that of other patients, or for nonpayment except as prohibited by titles XVIII or XIX. In theory, the

Secretary could terminate a facility from participation in the Medicaid program for violation of this standard. In practice, facilities are rarely terminated, and then only for serious violations of health and safety requirements.

The General Counsel has concluded that intermediate sanctions are legally unavailable for use in cases involving discrimination in nursing home access. Also, as a matter of policy use of intermediate sanctions in cases involving denial of access would be counter-productive, as the sanction is a prohibition of FFP for any new Medicaid admissions.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

August 19, 1985

DRAFT

NOTE TO: Members of the Working Group on Nursing Home Discrimination

FROM: Tim Miller, Executive Secretariat

Attached is your copy of the MEMORANDUM TO THE SECRETARY which has gone to the Secretary from the Under Secretary. Thank you all for your comments to my 8/16/85 DRAFT.

Given our commitment to continue the Working Group as an integral part of our action plan, I believe it would be appropriate to have another meeting in the near future. I'm on vacation this week and will contact each of you upon my return next Monday.

Attachment

Addresses

Edwin Marcus, HDS
Trisha Knight, ASL
Tom Morford, HCFA
Peter Jacobson, OCR
Liz Dunst, OGC
Steve Davis, OIG
Betty Stagg, HDS
Robert Binder

Jerry

KAREN RAHM
Secretary

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Olympia, Washington 98504

August 22, 1985

Thomas G. Wallner, Associate Regional Director
DHHS, HCFA
Division of Health Standards & Quality
2901 Third Avenue, MS 409
Seattle, Washington 98121

Dear Mr. Wallner:

The enclosed memorandum, dated August 6, 1985, identifies serious potential problems pertaining to the Patient Care and Services (PaCS) survey instrument and implementation. They can still be addressed, given appropriate action. This letter serves to request the regional office to forward our concerns to the Health Care Financing Administration.

There is strong support in this region and across the country, for an outcome-oriented survey process such as PaCS. However, there is also strong concensus of agreement that it would be ill advised to implement the PaCS system without a final evaluation of the PaCS format and without appropriate training of surveyors. Certainly, we can agree it doesn't make much sense to mandate the new use of an instrument effective January 1, when surveyors may not be trained in the use of the instrument until March of that year.

This matter is critical because the effectiveness of the survey process is dependent on the instrument and well trained surveyors. All decisions to enforce federal and state regulations protecting patient health and safety are derived from and defended by the survey document.

Your assistance in helping to assure a sound PaCS instrument and training, prior to implementation, will be greatly appreciated.

Sincerely,

Conrad Thompson

Conrad Thompson, Director
Bureau of Nursing Home Affairs
(206) 753-5840

CT:mw

Enclosure

cc: Joseph Anderson
Sharon Morrison ✓
Tom Robinson
Jerry Reilly

2507

DEPARTMENT OF HEALTH AND HUMAN SERVICES

[AUG 27 1985]
AUG

[FM:] Deputy Director
Health Standards and Quality Bureau

[RE:] Oregon's Failure to Conduct Annual Surveys of LTC Facilities

[TO:] Associate Regional Administrator
Division of Health Standards and Quality
Region X

This is in response to your memoranda dated June 10 and July 30. I apologize for the delay in responding, however, we have no record of receipt of the original June 10 memo.

Since the State of Oregon is unable or unwilling to conduct annual surveys of long term care facilities as required by law, the following steps should be taken:

1. Federal financial participation (FFP) should be disallowed for all Medicaid long term care facilities where provider agreements have been issued without the required annual onsite surveys. These provider agreements should be considered invalid and disallowance action should be initiated.

2. For Medicare facilities, the lack of annual surveys of long term care facilities is contrary to the provisions of the 1864 agreement. Moreover, any long term care provider agreement issued under Medicare, without an annual survey, is technically invalid. Therefore, none of the services furnished to Medicare beneficiaries are covered. I suggest you work closely with the Oregon survey agency to rectify this situation immediately.

The State should be reminded of: the potential disallowances of Federal financial participation for the State; that these actions are in conflict with the current 1864 agreement; and the potential adverse effect on Medicare beneficiaries.

If I can be of any further assistance, please let me know.

Thomas G. Morford

TerriC:wm:8/15/85:rc:8/16/85, tc 8-23&26-85/0005D

File Copy

OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE
	Terri C	8/26			
		8/26			

KAREN RAHM
Secretary

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Olympia, Washington 98504

August 28, 1985

file
1864
agreement

RECEIVED
SEP 4

Joseph E. Anderson
Regional Administrator
DHHS, HCFA
4901 Third Avenue, MS 409
Seattle, Washington 98121

Dear Mr. Anderson:

Enclosed please find the new "1864 Agreement," which, in spite of serious reservations, I have signed on behalf of the state of Washington. The state objects very strongly to the extremely one-sided nature of the agreement, as well as the lack of any meaningful opportunity to negotiate any changes in the language or the terms of the contract as proposed by the Health Care Financing Administration (HCFA).

Believing the agreement to be bilateral and subject to negotiation, the state, in good faith on June 4, 1985, proposed the addition of a new article to the agreement. The purpose of our proposed article entitled "Clarifications" was to provide the state with some assurance that HCFA would not change or impose new requirements upon the state without providing the state with 1) prior opportunity to comment, 2) reasonable notice to comply, and 3) adequate funding to meet the new or changed requirements. Enclosed is a copy of the article so you can share it with the central office.

The proposed article would also clarify that performance standards imposed upon the state are satisfied by substantial compliance. The rule of 100 percent absolute compliance is particularly troubling to the state. The federal system is replete with paper and calendar date requirements, which are not related to patient care outcomes. Less than absolute compliance has resulted in substantial monetary penalties against the state.

Joseph E. Anderson
August 28, 1985
Page two

Your letter of June 24, 1985 advised me our proposed modification to the contract could not be accepted. We have received no written response from the regional office or from HCFA headquarters to the specific concerns we have raised or the modification proposed to the contract.

Last Friday representatives from the Washington, Idaho and Oregon state agencies met with you to discuss concerns with the new 1864 Agreement. In reliance upon your assurances that, at least at the regional level, you will make every effort to be "rational, reasonable and temperate" in your interpretation and application of the contract, I signed this agreement.

It is our expectation that next year we will have an opportunity to negotiate the terms of the contract we believe are necessary if we are to continue to carry out Medicare survey responsibilities for the federal government in future years.

Sincerely,

Karen Rahm

KAREN RAHM
Secretary

Enclosures

bcc: Thomas Wallner, Associate Regional Admin., Region X
Bruce Ferguson, Assistant Secretary, Community Services
Gerald Reilly, Director, Division of Medical Assistance
Conrad Thompson, Director, BNHA
Peggy Brown, Assistant Attorney General
BNHA Program Managers
All Association of Health Facility Licensure
& Certification Directors
Steve Boeigheimer, Portland
Bob Ogden, Alaska
Darlene Aanderud, BNHA

ARTICLE XVI
CLARIFICATIONS

In order to avoid uncertainty and to ensure that certain provisions and terms of this Agreement are interpreted as the parties intend, it is further agreed by and between the parties that the following represents their mutual understanding and interpretation:

1. The imposition of any new requirements by the Secretary through general instructions authorized by this Agreement shall be conditioned upon the provision of adequate federal funding to meet any such requirements;

2. The Secretary shall not adopt through general instructions requirements that constitute rules under the federal Administrative Procedure Act (APA), 5 U.S.C. §§ 551, *et seq.*, and therefore are required to be adopted through APA rule-making procedures;

3. It shall always be "feasible and practicable" to provide the state with adequate lead time to respond to the Secretary's reporting requests under Article II-H;

4. Except in emergency circumstances, it shall be deemed "feasible and practicable" for the Secretary to request the state to participate in the development of general instructions, pursuant to Article III;

5. With respect to all requirements that the Secretary is herein authorized to impose unilaterally and with respect to all actions that the Secretary is authorized herein to take unilaterally, the Secretary shall act reasonably and give the state reasonable notice thereof;

6. In evaluating the state's performance pursuant to Article V, the Secretary shall find that the state has met a performance standard when the state has substantially complied with such performance standard;

7. The Secretary shall give the state reasonable notice of termination in the event that the Secretary terminates this Agreement pursuant to Article V-E or Article VIII-C. Also, the state has the right to appeal the Secretary's determination to terminate under these provisions.

8. In no event shall the Secretary take longer than 120 days to render a decision regarding a claim over $50,000 under Article XIV-E.

[DEPARTMENT OF HEALTH AND HUMAN SERVICES]

[Health Care Financing Administration]

Baltimore Md.

RECEIVED
SEP 17 1985
FACILITY STANDARDS
PROGRAM

AUG 30 1985

Mr. Louis Remily, President
Association of Health Facility Licensure
and Certification Directors
State of Wisconsin, Division of Health
Department of Health and Social Services
P.O. Box 309
Madision, WI 53701-0309

Dear Mr. Remily:

Thank you for sharing with me the concerns raised by your Executive Board regarding the implementation of our new patient-oriented survey (PaCS). I am glad you agree that the new survey process is superior to the present one.

As you know, over the past few years, we have devoted considerable staff resources to examining, modifying, and testing revisions to the survey process in long-term care facilities. We have conducted demonstrations and experiments which helped to delineate key factors and variables in the survey process. Using this information, we devised a survey process which takes into account the diversity of the States' survey programs. We have tested this process in our nationwide limited implementation and our three State experiments, and we are incorporating findings from this experimentation.

We are also working to implement the modified process in response to the court order in Smith v. Heckler. The Secretary's plan of action incorporates the implementation of PaCS as the method that will be used to assure high quality care in nursing homes. By October 31, we plan to publish a Notice of Proposed Rulemaking which would require the use of a patient-oriented survey in nursing homes. We will carefully consider all comments before implementing the PaCS process.

In response to your specific concerns, I am confident that each one will be appropriately resolved. Brown University has already submitted findings based on this year's activity in the three experimental States. As a result, we have changed the forms, and we have increased the number of items covered in the survey. Also, the evaluation of PaCS has occurred on several other fronts, including data from our nationwide limited implementation which has been analyzed by Rehabilitation Care

Consultants and data from monitoring surveys which has been analyzed both centrally and by our regional offices. We are confident that we have already addressed the majority of the questions about the process from these three sources. Finally, the remaining data being analyzed by Brown University are not expected to yield results that are significantly different from those already reported.

Second, interpretive guidelines will be available for training in December. Rehabilitation Care Consultants is preparing these guidelines as well as training materials according to our specifications. They are in frequent contact with our training staff. We are assured that the training materials will meet our needs and will be prepared in time for the first session in December.

Third, we will require only surveyors who have received the PaCS training to perform the new survey. We believe the initial group of State and Federal surveyors will be able to quickly train the remaining surveyors by utilizing our prepared training materials and audio-visuals.

This does NOT Resolve the problem!!

Our staff's utmost attention is devoted to completing the details of this new process, and I am confident there will be no major problems during the initial implementation. As stated earlier, we share your belief that the tool is superior to the current process. Substantial research and groundwork has been completed. I know you agree that we should all direct our best efforts to implementing a process that will assure high quality care in our nation's nursing homes.

Sincerely yours,

Philip Nathanson
Director
Health Standards and Quality Bureau

STATE OF IDAHO
DEPARTMENT OF HEALTH AND WELFARE
OFFICE OF THE DIRECTOR, STATEHOUSE, BOISE, IDAHO 83720

September 6, 1985

RECEIVED
SEP 6 1985
FACILITY STANDARDS PROGRAM

Joseph E. Anderson
Regional Administrator
Health Care Financing Administration
Department of Health and Human Services
Region X, M/S 502
2901 Third Avenue
Seattle, WA 98121

Dear Mr. Anderson:

I have signed the attached copy of the Section 1864 Agreement. This action will permit the State of Idaho to continue to carry out the state survey and certification process adjunct to state licensure and inspection-of-care for providers of Medicare-covered services.

I must express great frustration and disappointment at the failure of Region X to constructively respond to our extensive efforts to review and amend the Agreement. Due to our perception of its inadequacy (shared by many other states) we took the following steps to negotiate an amended Agreement:

1. On April 5, 1985 we mailed to you proposed changes that were intended to clarify several areas and provide equity of responsibility between the State Agency and Federal Government. Copies of these proposals are attached.

   We were informed by you in a letter dated April 18, 1985 that the Secretary would not consider such amendments at that time.

2. After further consideration and upon legal advice, we submitted to you on May 6, 1985 a signed 1864 Agreement which contained a new Article XVI. The changes proposed in Article XVI were a considerable dilution of the April 5 proposed amendments. I am attaching a copy of proposed Article XVI which clearly demonstrates the nature of our concerns.

On June 24, 1985 you returned the document to us indicating that you were unable to accept the signed Agreement as we had modified it by the addition of Article XVI. You offered to discuss and clarify our questions.

3. Jointly with representatives of Oregon and Washington we arranged a meeting with you on August 23, 1985 wherein the states requested at least a written response from you addressing the concerns raised in the proposed Article XVI. You made it very clear that you could not issue any such response or any written assurances concerning the implementation or administration of the Agreement.

   You did give verbal assurance, however, that you see our past relationship as productive and that any Agreement will be administered in a rational and reasonable manner, to the extent you have options. You also offered assistance in working toward a more acceptable Agreement in the future.

I have signed the Agreement even though I see it as one that is unilateral and one of adhesion, on the strength of your assurances and the belief that it may be possible to salvage an eroded and weakened federal-state partnership. I view the signed Agreement as only an interim measure pending a more satisfactory agreement next year, toward which, with the promised cooperation of Region X, the State of Idaho will immediately begin working.

Sincerely,

Rose Bowman

Rose Bowman
Director

RB:jl

Attachment

10/7/85 To [illegible]

Association of Health Facility Licensure and Certification Directors

Conrad Thompson

Date: September 11, 1985

To: Officers and Board Members
Association of Health Facility Licensure and Certification Directors

From: Louis E. Remily, President LER

Deputy Director
Bureau of Quality Compliance
Division of Health
P.O. Box 309
Madison WI 53701

RECEIVED
SEP 17 1985
FACILITY STANDARDS PROGRAM

Subject: HCFA Response to Executive Board's Position on PaCS Implementation

Attached for your information is Philip Nathanson's response to the August 7, 1985 letter which expressed the Board's opposition to implementing PaCS on January 1, 1986.

This reply addresses each of the four points mentioned by the Board as reasons for a more orderly implementation.

Especially note Mr. Nathanson's comment in the second to last paragraph that HCFA "will require only surveyors who have received the PaCS training to perform the new survey". This eliminates one of the Board's major concerns.

[illegible] money and [illegible] for [illegible] surveyors to [illegible] the [illegible]

It is suggested that each Board member forward a copy of this August 30, 1985 Nathanson letter to each state director in your region and also a copy of the August 7, 1985 letter to Mr. Nathanson from me if you have not already distributed that letter.

LER:jmb
enc.
cc: Thomas Vernon, M.D., ASTHO

9/29/85
FYI

bc: Dana Petrowsky
Elma Holder
Julie Trocchio
Sheldon Goldberg

CC [redacted]
Garlien A.
Chuck Hawley
Dave Soper
Sid Olson
Tom Robinson
Bill Gammon.

RECEIVED
OCT 1 1985
DSHS - BNHA
SURVEY PROGRAM

Consultants and data from monitoring surveys which has been analyzed both centrally and by our regional offices. We are confident that we have already addressed the majority of the questions about the process from these three sources. Finally, the remaining data being analyzed by Brown University are not expected to yield results that are significantly different from those already reported.

Second, interpretive guidelines will be available for training in December. Rehabilitation Care Consultants is preparing these guidelines as well as training materials according to our specifications. They are in frequent contact with our training staff. We are assured that the training materials will meet our needs and will be prepared in time for the first session in December.

Third, we will require only surveyors who have received the PaCS training to perform the new survey. We believe the initial group of State and Federal surveyors will be able to quickly train the remaining surveyors by utilizing our prepared training materials and audio-visuals.

Our staff's utmost attention is devoted to completing the details of this new process, and I am confident there will be no major problems during the initial implementation. As stated earlier, we share your belief that the tool is superior to the current process. Substantial research and groundwork has been completed. I know you agree that we should all direct our best efforts to implementing a process that will assure high quality care in our nation's nursing homes.

Sincerely yours,

Philip Nathanson
Director
Health Standards and Quality Bureau

cc: Solodky
9-23-85

MARTHA L. SOLODKY
Legislative Assistant to
Senator James A. McClure
Idaho
Washington, D.C. 20510
[illegible]

United States Senate
COMMITTEE ON APPROPRIATIONS
WASHINGTON, D.C. 20510

September 17, 1985

C. McClain Haddow
Acting Administrator
Health Care Financing Administration
200 Independence Avenue, SW
Washington, DC 20201

Dear Mr. Haddow:

I was recently contacted by Mrs. Rose Bowman, Director of the Idaho Department of Health and Welfare, about a matter I wish to bring to your attention.

On September 6, Mrs. Bowman sent Idaho's Section 1864 Agreement to the Region X office in Seattle. In her accompanying letter, Mrs. Bowman expressed extreme dissatifaction with Region X's lack of responsiveness to Idaho's efforts to amend and review the Agreement. I have enclosed a copy of Mrs. Bowman's correspondence with Mr. Joseph E. Anderson in Seattle.

It seems to me that the entire purpose of the Agreement is to find a process that is agreeable to both the states and to HCFA. However, the State of Idaho has been totally frustrated in its attempts at amending the agreement and feels HCFA has made unilateral decisions, with little or no consideration of the State's proposals.

While I would agree that it is important for HCFA to have signed Agreements in a timely manner, I also firmly believe that a federal-state partnership must be maintained. In this case, that partnership has not been equal.

I would appreciate hearing from you about this matter. I would further hope that when Idaho begins to draft its Agreement for next year, that the Seattle office will be more receptive to its proposals.

Thank you very much.

Sincerely,

James A. McClure
United States Senator

McC:ms

FILE COPY

STATE OF IDAHO
DEPARTMENT OF HEALTH AND WELFARE
STATEHOUSE
BOISE, ID 83720-9990

September 20, 1985

Margaret M. Heckler, Secretary
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue S.W.
Washington, D.C. 20201

Dear Ms. Heckler:

On September 6, 1985, I reluctantly signed the Section 1864 Agreement with the Department of Health and Human Services which will permit the State of Idaho to continue to carry out the Medicare State Survey and Certification process for the federal government. Certain events which led to the reluctant signing of the Agreement cause grave concerns to me and I am compelled to share them with you.

1. The federal agency requested input to the draft 1864 Agreement which was provided in a timely way by the Association of State and Territorial Directors of Licensing and Certification but it was not reflected in the final Agreement.

2. Contrary to earlier commitments made by the Health Care Financing Administration Central Office that the federal regional offices would be able to negotiate the terms of the Agreement with the individual States, the Health Care Financing Administration subsequently dictated the terms of the Agreement with no opportunity for negotiation, creating a contract of adhesion. Inability to negotiate terms of the Agreement obviates any State/Federal partnership and could lead to increased litigation between the States and the federal government. The absence of negotiation for equity flies in the face of the preface to the Medicare 1864 Agreement which states, "The 1864 Agreements are instrumental in facilitating the partnership between the Department of Health and Human Services and the States."

   The following reflect the steps taken by Idaho in an attempt to negotiate an Agreement:

On April 5, 1985, we mailed to the Region X Health Care Financing Administration office proposed changes that were intended to clarify several areas and provide equity of responsibility between the State agency and federal government. Copies of these proposals are attached.

We were informed by the Health Care Financing Administration in a letter dated April 18, 1985, that the Secretary would not consider such amendments at that time.

After further consideration and upon legal advice, we submitted, on May 6, 1985, a signed 1864 Agreement which contained a new Article XVI. The changes proposed in Article XVI were a considerable dilution of the April 5 proposed amendments. I am attaching a copy of proposed Article XVI which clearly demonstrates the nature of our concerns with the Agreement; i.e., the lack of assurances of equity, timeliness, and compliance with the federal Administrative Procedures Act when the federal government issues new procedures to the State agencies; that performance standards by the State agency must be 100 percent versus substantial compliance; and, that reasonable notice was not provided for unilateral requests made of the States by the Secretary and for any notice of termination of the Agreement. These assurances would have been dealt with in the attached proposed Article XVI which Region X rejected along with all other Idaho attempts to amend the document.

On June 24, 1985, the document was returned to us indicating that the Health Care Financing Administration was unable to accept the signed Agreement as we had modified it by the addition of Article XVI. The Health Care Financing Administration Regional Administrator offered to discuss and clarify our questions.

Jointly, with representatives from Oregon and Washington, we arranged a meeting with the Health Care Financing Administration Region X Administrator on August 23, 1985, at which time the States requested at least a written response addressing the concerns raised in the proposed Article XVI. The Region X Administrator made it very clear that he could not issue any such response or any written assurances concerning the implementation or administration of the Agreement.

Verbal assurance was given, however, that any Agreement will be administered in a rational and reasonable manner, to the extent that options are available.

3. Other States had severe difficulty with the Agreement as offered by the federal government and also signed under significant protest. We are aware of several legal opinions among the States that the signing of the Agreement, without amendment, places the State in the position of full control by the federal agency for the purposes of Medicare Survey and Certification.

I must express great frustration and disappointment at the failure of the Health Care Financing Administration to constructively respond to our extensive efforts to review and amend the Agreement. I have nonetheless signed the Agreement, even though I see it as one that is unilateral and one of adhesion, on the strength that it may be possible to salvage an eroded and weakened Federal/State partnership. I view the signed Agreement as only an interim measure pending a more satisfactory Agreement next year, toward which, with the promised cooperation of Region X, the State of Idaho will immediately begin working.

I am, therefore, requesting your support to Idaho and all other States in their attempt to negotiate an equitable Federal/State Agreement in the upcoming year.

Sincerely,

Rose Bowman

ROSE BOWMAN
Director

RB/nh

Attachments

cc: Representative Larry E. Craig
Representative Richard Stallings
Senator James A. McClure
Senator Steven D. Symms
C. McClain Haddow, Acting Administrator,
Health Care Financing Administration
Phillip Nathanson, Director, Health Standards and Quality Bureau

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date SEP 25 1985

Refer To: BPO-F33

From Director
Bureau of Program Operations

Subject Financial Management Review Guide for Provider Agreements (PAs) with Long-Term Care (LTC) Facilities--ACTION

To All Regional Administrators

Attached is a revised financial management review guide for Provider Agreements with Long-Term Care facilities. This revision is necessary to update the policy guidelines and related review procedures concerning annual facility surveys that appear in Section III.C. of our September 1982 PA review guide.

Prior to October 1, 1981, States were required to perform annual facility surveys to certify compliance before a valid provider agreement could be issued. However, because of survey budget reductions beginning in FY 1981, HCFA issued, on June 1, 1982, an interim national policy regarding annual surveys (see Guide, Exhibit P). Basically, this policy allowed the States the flexibility to prioritize their survey activities and to adjust the number and frequency of surveys to stay within their budget allocations. HCFA indicated that there would not be disallowances for providers not surveyed if the State could document that its decisions not to survey were based on a rational plan which set priorities in accordance with the historical compliance of facilities. This interim policy was in effect for the period October 1, 1981 to September 30, 1984.

On August 9, 1984, the Director, Health Standards and Quality Bureau (HSQB), advised the regions (see Guide, Exhibit S) that the interim policy had been eliminated and that they should now move aggressively to enforce full compliance with the requirement of annual facility surveys. However, it was noted that a liberal phase-in period to return to annual surveys would be allowed. The June 5, 1985 HSQB budget letter (see Guide, Exhibit T) to all regional offices, for transmission to all States, emphasized that all facilities must be surveyed and found in compliance during the phase-in period between October 1, 1984 and September 30, 1985, in order for their PA's to be valid.

We recommend that you take the necessary action to ensure that annual State surveys are being performed and that every LTC facility will have been surveyed at least once in the year prior to September 30, 1985. Beginning October 1, 1985, it will be necessary to initiate the appropriate disallowance action for those facilities which have not been surveyed. The revised review guide can be used by your staff in its monitoring of this area.

Also, we would like to take this opportunity to let you know that a proposed regulation regarding payment of Federal financial participation (FFP) after termination or expiration of a PA has been submitted to the Secretary. We are proposing that no FFP will be paid after the termination or expiration date regardless of any appeal. Adoption of this rule would effectively rescind the Medical Services Administration, Program Regulation Guide Number 11 and replace the Grant Appeals Board interpretation of HCFA policy known as the 12-month rule.

We are issuing this revised guide attached as a final guide. However, if you have comments or suggestions, please forward them to us within 2 weeks after you receive the guide. If you have any questions, please contact Gilda Martin, Division of State Agency Financial Management, on FTS 987-1399.

John C. Berry

Attachment

cc:
All Associate Regional Administrators
  for Financial Operations

ATTACHMENT

TITLE XIX FINANCIAL MANAGEMENT REVIEW GUIDE

No. 6: PROVIDER AGREEMENTS WITH LONG TERM CARE FACILITIES

Prepared by the Health Care Financing Administration

Division of State Agency
Financial Management, BPO

August 1985

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I. Introduction

This guide is a revision of the September 1982 Title XIX Financial Management Review Guide No. 6: Provider Agreements with Long Term Care (LTC) Facilities. It is intended to provide specific instructions on performing a financial management review to determine the allowability of Federal financial participation (FFP) for services furnished by skilled nursing facilities (SNFs) and intermediate care facilities (ICFs). The guide reflects current law, regulation, policy, and Grant Appeals Board (GAB) decisions.

In preparing a guide for financial review of provider agreements (PAs) with LTC facilities, central office recognizes that the Health Standards and Quality Bureau (HSQB) and the Division of Program Operations (DPO) are responsible for determining the validity of Medicaid PAs and giving program advice to the States. It is intended that the guide will give financial personnel the basic knowledge, references, and review steps necessary to ascertain whether a State's claims for FFP are allowable. The regional office will decide which of its divisions will supply personnel to be members of any review team.

The methods and procedures detailed in this guide are based on the experience of various regional office staffs. The users should understand that there may be circumstances which are unique to individual reviews which will require the use of additional methods and procedures not specified in this guide. The situation may also suggest the elimination or modification of methods and procedures which have been specified. The use of this guide in conjunction with the individual reviewer's professional judgment will assist in completing a financial management review which satisfies all requirements in this area.

II. Basic References

The basic references are included as exhibits in Section VII of this guide, as listed below. (The 1983 edition of the Social Security Act and the 1984 edition of the 42 CFR have been cited.)

Exhibit	Page
A. Section 1861(j) of the Act................................	15-15.1
B. Sections 1866(a) and (b) of the Act, including Amendment made by Section 2153 of the Omnibus Budget Reconciliation Act of 1981 (OBRA-81).....................................	16-16.6
C. Section 1902(a)(27) and (a)(28) of the Act...............	17
D. Section 1902(a)(33)(B) of the Act.........................	18
E. Section 1903(a) of the Act................................	19-19.1
F. Section 1905(c), (d), (f), and (i) of the Act............	20-20.1

Exhibit | Page

G. Section 1910(a) and 1910(c) of the Act.................... 21

H. Section 916(a), (b)(1), and (b)(2) of the Omnibus Reconciliation Act of 1980 (ORA-80)....................... 22-22.2

I. Regulation 42 CFR Part 431................................. 23

J. Regulation 42 CFR 441.11.................................. 24

K. Regulation 42 CFR 442.12, 442.13 and 442.14.............. 25

L. Regulation 42 CFR 442.15 and 442.16...................... 26

M. Regulation 42 CFR 442.30.................................. 27

N. Regulation 42 CFR 489.13 - .18............................ 28

[*] O. Proposed Regulation (Federal Register 47, May 27, 1982, pages 23404 - 23414)....................................... 29-29.10

[*] P. HCFA's June 1, 1982 Policy Statement on Time Limited Agreements.. 30-30.1

Q. Guidelines to Grant Appeals Board Decisions; also PRG-11 dated December 20, 1971.................................. 31-31.7

[*] R. Proposed Regulation (Federal Register 50, February 21, 1985, pages 7191 - 7198).................................. 32-32.7

[*] S. Memo regarding enforcement of time limited agreements and other Subpart S requirements dated August 9, 1984........ 33

[**] T. HSQB's June 5, 1985 budget letter to Regional Administrators; see pages 2 and 5 regarding annual surveys......... 34-34.10

III. Background

A. Law

Under the Medicaid program, Section 1902(a)(27) of the Social Security Act (the Act) requires the State to have a PA with every person or institution providing services under the State plan.

The definition of a SNF is found in Section 1902(a)(28) of the Act with reference to Section 1861(j). The definition of ICFs is found in Sections 1905(c) and (d) of the Act.

Section 1902(a)(33)(B) states that the State survey agency will determine whether institutions and agencies meet the requirements for participation in the Medicaid program under the State plan. In addition, this section provides that the Secretary is authorized to make independent and binding determinations concerning the extent to which individual institutions meet the requirements for participation where there is cause to question the adequacy of a State survey agency determination. The "look behind" provision in this section was added by Section 916(b)(2) ORA-1980.

Sections 1903(a)(1) through (a)(7) of the Act specify that the Secretary shall pay the State a percentage of the amount it expended for medical assistance and certain administrative expenses under the State plan.

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[*] [These documents appear in the Appendix of internal HHS documents, in chronological order.]

[**] [Not received by Committee.]

Section 916(a) and (b)(1), ORA-1980, added Sections 1866(f) and 1902(i) of the Act to provide intermediate sanctions against LTC facilities. The sanctions deny payment for services for individuals who have been admitted after the effective date of the sanctions. These sanctions are applied by HSQB for Medicare and the State agency for Medicaid.

Section 1910(a) requires that an SNF found to meet the requirements for Medicare is deemed to meet the requirements for Medicaid.

Section 1910(c), added by Section 916(b)(2), ORA-1980, gives the Secretary "look-behind" authority to cancel the approval of a SNF or ICF at any time. (Regulation 42 CFR 442.30, which has been in effect since 1974, is the "look-behind" authority in situations where either the State survey agency made an improper determination in certifying that a facility met Federal requirements or the State Medicaid Agency issued a PA not consistent with the survey agency's action.)

Section 2153 of the OBRA-81 removed the statutory requirement that a PA for SNFs may not exceed a maximum term of 12 months. This change was made by deleting a sentence from Section 1866(a)(1) of the Act and did not mandate the removal of the regulatory 12-month limitation. As a general rule, statutory authority overcomes regulatory requirements. However, in this case the deletion of the statutory requirement for a maximum term of 12 months for a PA did not alter the authority of 42 CFR 442.15, which limits the duration of a PA to 12 months.

B. Regulations

It is impractical to review all the regulations pertaining to certifications and PAs of LTC facilities. For the most part, they are found in 42 CFR Part 442. You may need to refer to other regulations, such as 42 CFR Part 405, Subpart K for the Medicare conditions of participation; 42 CFR 440.40 and 440.150 for general provisions regarding SNF and ICF services; or 42 CFR Part 431, Subpart D for LTC facility Medicaid appeal procedures.

Certification of Compliance Needed for Valid PA

Regulation 42 CFR 442.12(a) provides that the State Medicaid agency may not execute a PA or make Medicaid payments for SNF or ICF services unless the Secretary or the State survey agency has approved the facility under Part 442 to provide those services. The Secretary, through the HSQ Regional Office (DHSQ), makes the final determination for Medicare. For Medicaid-only SNFs and ICFs (Medicare does not furnish ICF services), it is the State survey agency that makes final determinations on a provider's compliance. Therefore, you would look to the State survey agency's certification for Medicaid-only SNFs and ICFs. If a facility furnishes SNF services to both Medicare and Medicaid, the DHSQ decision regarding compliance for Medicare is binding on Medicaid for SNF services. Again, you would look to the State survey agency's certification decision for ICF services in a dual facility. Also see Dual Facilities, page 9 of this guide.

Effective Date of Certification

Regulation 42 CFR 442.13 (effective July 3, 1980, for Medicaid and corresponding regulation 42 CFR 489.13 effective May 5, 1980 for Medicare) defines the effective date of a PA. If all Federal requirements are met on the date of survey, the effective date of certification is the date the onsite survey was completed (or the day following the expiration of a current agreement). If all requirements are not met on the date of survey, a PA can become effective (1) when the requirements are met, or (2) on the date the provider submits an acceptable plan of correction (POC) or an approvable waiver, whichever is earlier. (If both a POC and waiver are needed, the PA cannot be effective until both an acceptable POC and an approvable waiver have been submitted.)

If your review involves the determination of the effective date of certification prior to July 3, 1980, the date 42 CFR 442.13 became final, you should refer to Exhibit Q, Part III, page 31.3.

Change of Ownership

When there is a change in ownership, 42 CFR 442.14 (for Medicaid) and 42 CFR 489.18 (for Medicare) require that the PA be assigned to the new owner. The new owner is subject to all the conditions of the transferred PA such as a POC and expiration date.

30-Day Relocation Period

Regulation 42 CFR 441.11 allows the State Medicaid agency, when it terminates or refuses to renew a provider, to continue to claim FFP for payments to the provider for up to 30 days of additional services. It may claim reimbursement only for patients who had been admitted prior to the effective date of termination and only if it is making reasonable efforts to relocate these patients to participating facilities. Thus, the determination of the amount of allowable FFP must be made on a patient-by-patient basis.

Extension of Provider Agreement

Regulation 42 CFR 442.16 allows the State Medicaid agency to extend a PA up to 2 months if it receives, in writing, a notice from the State survey agency that the extension is needed to prevent irreparable harm to the facility or hardship to the recipients in the facility or that it is impracticable to determine, before the expiration date, whether a facility meets program requirements. Note that only one of these two requirements must be met. However, in all cases, the survey agency must determine and certify to the single State agency in writing that the extension will not jeopardize the patients' health and safety before the extension may be granted. The survey agency notice must be transmitted before the expiration date of the PA. If a SNF participates in both Medicare and Medicaid, both the Medicare and Medicaid agreements must be extended.

"Look Behind" Provisions

Regulation 42 CFR 442.30 (first promulgated November 13, 1974) has given the Secretary the authority to "look behind" Medicaid certification decisions. If the certification of compliance made by the State survey agency is found to be in error, the PA for that provider is considered, for FFP purposes, invalid from its inception. In this situation FFP should be disallowed to the State for those periods of time when the facility's PA is found to be invalid.

Section 1910(c) of the Act (added by Section 916(b)(2), ORA-1980) is a new "look behind" authority giving the Secretary the authority to cancel, at any time, the approval of any SNF or ICF. This cancellation of approval terminates a facility at the time the facility is found to be out of compliance as opposed to the look behind under 42 CFR 442.30, which is a sanction against the State when a certification of compliance was not properly made. Since no payment to the provider should be made after the date of the termination of the agreement as set by the Secretary under Section 1910(c), a disallowance should not be necessary. However, a disallowance should be taken if a claim is made for expenditures after the termination date specified by the Secretary.

Intermediate Sanction

Secton 1902(i) of the Act (added by Section 916(b), ORA-1980) provides that the State may impose an intermediate sanction as an alternative to termination where it determines that a SNF or ICF certified for participation under the State plan no longer substantially meets applicable requirements, but that the deficiencies do not immediately jeopardize patient health and safety. The alternative sanction denies payment for services to an individual admitted after the effective date of the sanction. (Some States may have been implementing such an intermediate sanction under a State law which predated the Federal authority.)

Regulations were proposed on February 21, 1985 to implement Sections 1902(i) and 1866(f) of the Act. (Section 1866(f) is the Secretary's authority to impose a similar sanction against a SNF certified to provide services for title XVIII and to order the State to impose the same sanction against the SNF for title XIX services.) Copy of the proposed regulations are included at Exhibit R. You are cautioned that these regulations may be changed in response to public comment before they are approved as final regulations.

C. Guidelines

Time Limited Agreements/Annual Surveys

o General Policy

The law and regulations cited above and the pertinent GAB decisions (see summary, Exhibit Q) are the basis for your PA review. A skeleton recap of the PA requirements which most often lead to a disallowance follows:

1. A SNF or ICF must have a valid PA before the State is eligible for FFP in services furnished by the facility. A PA is not valid unless the State survey agency (or the Secretary for a SNF also participating in Medicare) has made the determination that the facility can be certified as meeting Federal requirements based on surveys conducted on at least an annual basis.
2. A PA is effective on the date a survey is completed (or on the day following the expiration of a current agreement) if all Federal health and safety standards and any other requirements imposed by the Medicaid agency are met. If all requirements are not met, the PA is effective on the date the facility comes intc compliance or on the date it submits an approvable plan of correction, whichever is earlier.
3. The maximum term of a PA is limited to 12 months.

While the statutory requirement for a maximum 12-month term for a time limited agreement (TLA) for SNFs was removed by OBRA-81, as discussed on page 3, the law as stated (see Exhibit B, page 16) did not invalidate 42 CFR 442.15 requirements for a maximum term of 12 months. Regulations were proposed (see Exhibit O, page 29) to remove the regulatory requirement for a 12-month maximum TLA for all LTC facilities. However, in response to public comment, these changes in the regulations are still being considered.

o Interim Policy

Repeal of the statutory requirement for 12 month maximum TLA's for SNFs , together with severe survey budget reductions mandated by

Congress in fiscal years (FYs) 1981 and 1982, led HCFA to conclude that annual surveys could not be completed for all facilities. The States were directed to develop plans to stratify facilities, identifying those with the best and the worst history of compliance. Funds were to be utilized to survey those with the worst history on a priority basis. If funds were depleted before surveys were completed for all facilities, including those with the best history of compliance, PAs were to be reissued without the required survey. To confirm this interim policy, the Associate Administrator for Operations on June 1, 1982 wrote that a disallowance of FFP to any State for providers not surveyed annually would not be approved if the State documented that decisions not to survey were based on a rational plan which set priorities in accordance with the historical compliance of facilities (see Exhibit P). This interim policy was in effect for the period October 1, 1981 to September 30, 1984.

During this interim period (October 1, 1981 to September 30, 1984) when less frequent than annual surveys were permitted under certain conditions, the planning and actions taken by the State will determine the allowability of FFP. If the State had no rational plan for allocating the limited survey funds to facilities with a history of noncompliance, a disallowance would be taken as usual. Certainly if a facility was surveyed and found not to be in compliance, a disallowance would be appropriate. However, a disallowance would not be appropriate if the State documents that

(1) it developed a rational plan to accommodate the budget restrictions, and

(2) the State survey agency notified the single State agency that a facility was not being surveyed, in accordance with the interim procedures, but that certification was being extended anyway.

On August 9, 1984, the Director, HSQB, advised the regions (see Exhibit S) that the conditions leading to the interim policy had been eliminated, and that it was now necessary to return to full compliance with the general policy requiring annual facility surveys. However, it was decided that a phase-in period to return to annual surveys would be allowed. Towards this end the June 5, 1985 HSQB budget letter (see Exhibit T) to all regional offices, for transmission to every State, emphasized that all facilities must be surveyed and found in compliance during the phase-in period between October 1, 1984 and September 30 1985, in order for their PAs to be valid. Therefore, beginning October 1, 1985, no PA is valid unless the facility has been surveyed, and found to be in compliance with applicable standards, within the preceding 12-month period.

The following table briefly summarizes the applicable policy on annuals surveys for the various time periods.

Period of Time	Applicable Policy
1. Before October 1, 1981	Annual surveys required. Survey and certification of compliance required for valid PA.
2. October 1, 1981 - September 30, 1984	Interim policy in effect. PA can be valid without annual survey if State developed and followed a rational plan which sets priorities in accordance with the historical compliance of facilities.
3. October 1, 1984 - September 30, 1985	Annual surveys required, but this is the phase-in period, during which all Medicaid-participating facilities must be surveyed. The facility will not be subject to a disallowance unless not surveyed by 10/1/85.
4. October 1, 1985 and thereafter	Every facility must have been surveyed during the preceding 12-month period, or its PA is invalid.

"Look Behind" Procedures

These procedures, which are implemented by HSQB, should not be confused with terminations and hearings under other circumstances, such as State survey agency determination of noncompliance. (Provider appeal of a State agency determination would be under 42 CFR 431.)

1. Section 916(b)(2), ORA-80, added Section 1910(c) of the Act authorizing HCFA to cancel the approval of any SNF or ICF at any time, if HCFA finds that the facility does not meet eligibility requirements.

2. The DHSQs will initiate these actions and in doing so will establish an effective date of cancellation:

    a. If the provider files for a hearing before an administrative law judge (ALJ), FFP will continue as required by section 1910(c)(2) until the hearing decision is rendered.

    b. If the provider does not file for a hearing, FFP will cease in accordance with 42 CFR 441.11.

c. If the OHSQ certifies that patients are in serious and immediate jeopardy, FFP should cease in accordance with 42 CFR 441.11. In such cases, the ALJ hearing is afforded after the effective date of termination.

Provider Agreement Not Executed

The absence of a PA usually indicates that the facility had not been certified as having met Federal requirements. The survey documents spell out the deficiencies, showing why the facility is not certified for participation.

There have been some instances in which the facility was approved by the State survey agency and met the civil rights requirements of 42 CFR 442.12(d)(2) and the disclosure requirements of 42 CFR 455.104 - .106, but no PA had been executed. The single State agency did not have "good cause" under 42 CFR 442.12(d)(1) to refuse to execute a PA and all Federal requirements were met. The reason for failure to execute the PA could be inadvertence or poor administration. In these cases, no disallowance should be recommended, as a PA can be executed to cover retroactively periods when all requirements are met. The review team responsible for the "Administration and Management" portion of the State assessment review should be advised of this discrepancy.

On the other hand, if the facility has been surveyed and found qualified but the single State agency did not execute a PA for "good cause" or other authority and yet continued to pay the provider, we would disallow. The authority for this disallowance would be that the expenditures were not allowed as amounts expended under the State plan as required by Section 1903(a)(1) of the Act.

Do not confuse the authority to execute a PA retroactively with the effective date of certification. Regulation 42 CFR 442.13 and 489.13 specify the date a certification becomes effective (discussed on page 4).

Dual Facilities and Medicaid-only Facilities

Different rules may apply to the facilities furnishing services for Medicaid only as opposed to a facility furnishing services under both Medicaid and Medicare. Since the Medicare program does not include ICF services, the allowability of FFP for ICF services is always determined by reference to Medicaid regulations regardless of the facility's SNF services performed under Medicare/Medicaid. The allowability of expenditures for SNF services is determined by Medicaid regulations unless the facility is also furnishing SNF services under Medicare. If the facility is certified to provide SNF services under Medicare, it is automatically certified to provide SNF services under Medicaid for the same period.

D. Grant Appeals Board (GAB) Decisions

The GAB (or Board) decisions have affected our policy in several instances. The Board has no authority to change policy developed in consideration of law and regulations, but since HCFA has no appeal from its final decisions we must adjust our practices accordingly until we set forth our policy through duly promulgated regulations or policy issuances.

A summary of the most important GAB decisions relating to PAs was provided to the regions by central office on October 27, 1981 (see Exhibit P). Central office also sends a copy of all GAB decisions involving a HCFA appeal to each regional office for your use.

IV. Purpose and Scope

The purpose of this review is to determine whether LTC facilities have valid PAs and that the FFP claimed by the States for their expenditures is allowable. The regions will define the period of time to be reviewed and determine the extent to which DHSQ or DPO should be asked to participate in the review.

V. Review Procedures

A. Regional Office Procedures

Certain review steps, including a decision on the period to be reviewed, should be completed in the regional office before you contact the State agency.

1. Review recent developments in the PA area such as GAB decisions, publication of proposed or final regulations, and guidelines from central office.
2. Review that section of the State plan dealing with PAs for change in procedures, appeal procedures, any general information and terminology, etc.
3. Check for Program Validation, "look behind" or other reviews or audits relating to this issue.
4. Obtain information from the Division of Program Operations regarding State problems with particular facilities, media publicity, etc. Review State Assessment findings which are available and appropriate to this review.
5. Solicit the cooperation of the DHSQ. The request for their technical expertise may include their actual participation in the review as well as the use of all information compiled by their office. The financial review should not replicate any work previously done by DHSQ.

Most regions have a Medicare/Medicaid Automated Certification System (MMACS). Each regional OHSQ office should have a list of all Medicare SNFs and all Medicaid SNFs, ICFs, and ICF/MRs with dates of surveys. The OHSQ may know what homes will be surveyed for title XIX. Become thoroughly familiar with any other OHSQ lists and information summaries. Even if you find the information from the OHSQ is duplicated in the State agency, use it for verification of the accuracy of the State information. You will be able to secure a list of all the facilities which have been terminated and those for which the certification date has been changed as a result of "look-behind" authority. These facilities should then be reviewed for any potential disallowance.

Ascertain from the OHSQ whether the State agency is conducting surveys of all their SNFs and ICFs on an annual basis.

6. If your review includes the interim policy period regarding annual surveys (October 1, 1981 through September 30, 1984), you will need to ascertain from the OHSQ or the State agency itself the State agency's policy for surveying all their SNFs and ICFs on an annual basis or their interim procedures in lieu of annual surveys. If, because of budget limitations, all facilities were not surveyed during the interim policy period, review the State's procedures for selecting those facilities which were surveyed. This review is not for the purpose of approving their plan for surveying or not surveying. But if the State extended PAs without a survey and without having developed a plan for surveying some facilities on other than an annual basis, a disallowance should be recommended. A listing of facilities not scheduled for survey under the interim workplan can be used as a screening device. If you have a list of all those not scheduled for survey in the fiscal year(s) covered by your review, you will know that these facilities were eligible for an extended PA without being surveyed. You should verify that the single State agency has taken the necessary action to continue the agreement. Thereafter, your review can focus on those facilities not scheduled to have their PA extended without a survey.

B. State Medicaid Agency Procedures

1. Hold an entrance conference with the State Medicaid agency to advise the State staff of the general scope and purpose of the review, expected dates for performance of the review, records which are needed, work space and facilities needed and any other requirements for completion of the review. Request that the State agency have a representative of the survey agency attend the conference. Secure from the State the procedures a provider should follow if it appeals, under 42 CFR 431.151 - .154, a decision made by the State survey agency that the facility has not met Federal requirements for participating in the program.

2. Obtain the following information from the State Medicaid agency if at all possible (if problems develop regarding certain facilities, the reviewers may have to seek additional information from the State survey agency):

   a. Identify the universe of LTC facilities furnishing Medicaid services to the State. As a time saving measure, you may want to make a specific request for this information before going to the State agency. Through State payment records, establish that the State is claiming FFP on the Form HCFA-64 only for the facilities identified. Compare with MMACS or other data obtained from the OHSQ. Resolve discrepancies as necessary.

   b. Test the facilities which have been issued PAs to determine that those facilities have been found in compliance with all Federal requirements. Establish that the State is performing surveys on at least an annual basis and that executed PAs are based on surveys. To be valid, any PA before October 1981 and after September 1985, must have had an underlying survey which established the facility's compliance. The State's individual implementation of the interim policy regarding surveys during the period October 1, 1981 through September 30, 1984 will determine the need for an underlying survey in that period. (See discussion beginning on page 6 regarding time limited agreements and annual surveys.)

      This test is not intended to be a review of the compliance determination but only a verfication that the certification and transmittal document (HCFA-1539) established compliance or that, during the interim period, the State agency issued a PA in accordance with its workplan for less than annual surveys.

   c. Identify those facilities within the period of the review which do not have a valid PA in effect but for which the State is claiming FFP.

   d. Establish the reason a PA has not been executed, such as waiting for the facility to submit a plan of correction, delay in scheduling and performing a survey, denial of a license by the State, or the State survey agency erroneously waiting for HSQB to make a decision.

   e. Establish that a facility furnishing services after September 30, 1985 was surveyed and certified as being in compliance between October 1, 1984 and September 30, 1985.

   f. Review the individual provider's file to determine if the reason for no PA, where found, is acceptable. Situations in which State payments are not eligible for FFP include the following among others:

(1) An extension of a PA for up to 2 months was granted under 42 CFR 442.16, but the State survey agency did not certified in writing that the health and safety of the patients would not be jeopardized or that the extension was needed for an acceptable reason.

(2) The State continues to pay the provider without a PA even though the provider has not appealed the survey agency's determination that the facility is not qualified to participate in the program.

(3) The State paid the facility for services rendered between the lapse of the PA and the date the facility appealed, in violation of Federal policy. The date of appeal is the date the facility requests a hearing under State law or secures a court order enjoining the State from terminating the provider.

In the case of a court order, the GAB has held that FFP is allowable for services rendered prior to the date of the order but not prior to the date of a decertification notice. (See page 8, GAB decision no. 368, December 20, 1982.)

Further, the GAB ruled that HCFA must participate, under the terms of PRG-11, in State payments to a provider for up to 12 months after a PA has expired if the facility is appealing the certification decision and if State law or a court order keeps the PA in effect during the appeal. HCFA will not allow FFP beyond the 12-month period. For example, if the provider appealed at the end of the third month after the PA lapsed, we would not allow FFP for the first 3 months but would for the next 9 months, if all the requirements of PRG-11 are met. See Exhibit Q, page 31 for further guidance.

(4) If the provider has not disclosed ownership or control information as required by 42 CFR 455.104 and refuses to comply upon specific request, the amount claimed should be included in your report as unallowable. Also, include any amount claimed if the State has not executed a PA because of the criminal conviction of a principal (42 CFR 455.106(c)).

C. Summary and Final Procedures

1. Establish the period of time during which the services furnished are not eligible for FFP, for each facility.

2. Calculate the amount paid in the review period for services not eligible for FFP. This computation must be for each individual facility for that period of time when the facility did not meet the requirements for Federal matching.

3. Separately state the finding for each home for each quarter if the review covers more than one quarter. The date the State made payment to the facility (by month) and the corresponding service dates should be included in the finding.

An exit conference with the State agencies should be held to present the findings, verify the facts leading to the findings, and solicit any additional information the State believes will affect the findings. Absent any indication of additional facts to be developed, solicit the State's written concurrence with the specific findings.

Note that some of the review steps listed above may be completed in some regions after return to the regional office.

VI. Development of Findings and Recommendations

The findings and recommendations established through your review will normally be developed and presented in a final financial management review report to the State. You should also submit the report to DHSQ for review and discussion, and reconciliation of any differences. The report generally should be structured as follows:

A. Background
B. Purpose and Scope
C. Findings
D. Conclusions
E. Recommendations
F. Supporting Attachments/Appendices

You should ensure that your report details the findings developed in section V.C. above. The report must cite the legal authority for any finding which will result in disallowance. (Also, cite GAB decisions and HCFA policy where appropriate). The report will then serve as the basis for any future disallowance action.

The final report should be submitted to DHSQ for informational purposes. The final report should then be transmitted to the State agency with your recommendations. You should indicate in the transmittal the actions you expect from the State agency as a result of your recommendations, and specify that a formal disallowance will be issued if any necessary financial adjustments are not made.

Exhibit A, page 15

Section 1861(j) of the Act.

Skilled Nursing Facility[1]

(j) The term "skilled nursing facility" means (except for purposes of subsection (a)(2)) an institution (or a distinct part of an institution) which has in effect a transfer agreement (meeting the requirements of subsection (l)) with one or more hospitals having agreements in effect under section 1866 and which—

(1) is primarily engaged in providing to inpatients (A) skilled nursing care and related services for patients who require medical or nursing care, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

(2) has policies, which are developed with the advice of (and with provision of[2] review of such policies from time to time by) a group of professional personnel, including one or more physicians and one or more registered professional nurses, to govern the skilled nursing care and related medical or other services it provides;

(3) has a physician, a registered professional nurse, or a medical staff responsible for the execution of such policies;

(4)(A) has a requirement that the health care of every patient must be under the supervision of a physician, and (B) provides for having a physician available to furnish necessary medical care in case of emergency;

(5) maintains clinical records on all patients;

(6) provides 24-hour nursing service which is sufficient to meet nursing needs in accordance with the policies developed as provided in paragraph (2), and has at least one registered professional nurse employed full time;

(7) provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals;

(8) has in effect a utilization review plan which meets the requirements of subsection (k);

(9) in the case of an institution in any State in which State or applicable local law provides for the licensing of institutions of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing institutions of this nature, as meeting the standards established for such licensing;

(10) has in effect an overall plan and budget that meets the requirements of subsection (z);

(11) complies with the requirements of section 1124;

(12) cooperates in an effective program which provides for a regular program of independent medical evaluation and audit of the patients in the facility to the extent required by the programs in which the facility participates (including medical evaluation of each patient's need for skilled nursing facility care);

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[1] See P.L. 95-142, "Medicare-Medicaid Anti-Fraud and Abuse Amendments" §21(b), with respect to publication of regulations defining charges which may be made against patients' funds.

[2] As in original. Probably should be "for".

Continued
Section 1861(j)
of the Act

(13) meets such provisions of such edition (as is specified by the Secretary in regulations) of the Life Safety Code of the National Fire Protection Association as are applicable to nursing homes, except that the Secretary may waive, for such periods as he deems appropriate, specific provisions of such Code which if rigidly applied would result in unreasonable hardship upon a nursing home, but only if such waiver will not adversely affect the health and safety of the patients, except that the provisions of such Code shall not apply in any State if the Secretary finds that in such State there is in effect a fire and safety code, imposed by State law, which adequately protects patients in nursing facilities;[1]

(14) establishes and maintains a system that (A) assures a full and complete accounting of its patients' personal funds, and (B) includes the use of such separate account for such funds as will preclude any commingling of such funds with facility funds or with the funds of any person other than another such patient, and

(15) meets such other conditions relating to the health and safety of individuals who are furnished services in such institution or relating to the physical facilities thereof as the Secretary may find necessary (subject to the second sentence of section 1863), except that the Secretary shall not require as a condition of participation that medical social services be furnished in any such institution. Notwithstanding any other provision of law, all information concerning skilled nursing facilities required by this subsection to be filed with the Secretary shall be made available to Federal or State employees for purposes consistent with the effective administration of programs established under titles XVIII and XIX of this Act;

except that such term shall not (other than for purposes of subsection (a)(2)) include any institution which is primarily for the care and treatment of mental diseases or tuberculosis. For purposes of subsection (a)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection. The term "skilled nursing facility" also includes an institution described in paragraph (1) of subsection (y), to the extent and subject to the limitations provided in such subsection. To the extent that paragraph (6) of this subsection may be deemed to require that any skilled nursing facility engage the services of a registered professional nurse for more than 40 hours a week, the Secretary is authorized to waive such requirement if he finds that—

(A) such facility is located in a rural area and the supply of skilled nursing facility services in such area is not sufficient to meet the needs of individuals residing therein,

(B) such facility has one full-time registered professional nurse who is regularly on duty at such facility 40 hours a week, and

(C) such facility (i) has only patients whose physicians have indicated (through physicians' orders or admission notes) that each such patient does not require the services of a registered nurse or a physician for a 48-hour period, or (ii) has made arrangements for a registered professional nurse or a physician to spend such time at such facility as may be indicated as necessary by the physician to provide necessary skilled nursing services on days when the regular full-time registered professional nurse is not on duty.

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[1] See P.L. 96-499, "Omnibus Reconciliation Act of 1980", §915(b), with respect to Life Safety Code requirements.

Exhibit B, page 16

Section 1866(a) of the Act, 1980 edition prior to amendment by OBRA - see below

Agreements With Providers of Services

Sec. 1866. (a)(1) Any provider of services (except a fund designated for purposes of section 1814(g) and section 1835(e)) shall be qualified to participate under this title and shall be eligible for payments under this title if it files with the Secretary an agreement—

(A) not to charge, except as provided in paragraph (2), any individual or any other person for items or services for which such individual is entitled to have payment made under this title (or for which he would be so entitled if such provider of services had complied with the procedural and other requirements under or pursuant to this title or for which such provider is paid pursuant to the provisions of section 1814(e)), and

(B) not to charge any individual or any other person for items or services for which such individual is not entitled to have payment made under this title because payment for expenses incurred for such items or services may not be made by reason of the provisions of paragraph (1) or (9), but only if (i) such individual was without fault in incurring such expenses and (ii) the Secretary's determination that such payment may not be made for such items and services was made after the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this title, and

(C) to make adequate provision for return (or other disposition, in accordance with regulations) of any moneys incorrectly collected from such individual or other person, and

(D) to promptly notify the Secretary of its employment of an individual who, at any time during the year preceding such employment, was employed in a managerial, accounting, auditing, or similar capacity (as determined by the Secretary by regulation) by an agency or organization which serves as a fiscal intermediary or carrier (for purposes of part A or part B, or both, of this title) with respect to the provider.[1]

An agreement under this paragraph with a skilled nursing facility shall be for a term of not exceeding 12 months, except that the Secretary may extend such term for a period not exceeding 2 months, where the health and safety of patients will not be jeopardized thereby, if he finds that such extension is necessary to prevent irreparable harm to

Second sentence deleted by OBRA-81, below

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[1] Subparagraph (D) was added by section 15 of P.L. 95-142.

REPEAL OF STATUTORY TIME LIMITATION ON AGREEMENT WITH SKILLED NURSING FACILITIES

1 Section 2153 of OBRA-81

Sec. 2153. Section 1866(a)(1) of the Social Security Act is amended by striking out the second sentence.

1983 edition of
Section 1866(a) of the Act follows. see page 16.1-16.5

Exhibit B, page 16.1

Section 1866(a)
of the Act
1983 edition

AGREEMENTS WITH PROVIDERS OF SERVICES

SEC 1866 [4. U.S.C 1395cc] (a)(1) Any provider of services (except a fund designated for purposes of section 1814(g) and section 1835(e)) shall be qualified to participate under this title and shall be eligible for payments under this title if it files with the Secretary an agreement—

(A) not to charge, except as provided in paragraph (2), any individual or any other person for items or services for which such individual is entitled to have payment made under this title (or for which he would be so entitled if such provider of services had complied with the procedural and other requirements under or pursuant to this title or for which such provider is paid pursuant to the provisions of section 1814(e)),

(B) not to charge any individual or any other person for items or services for which such individual is not entitled to have payment made under this title because payment for expenses incurred for such items or services may not be made by reason of the provisions of paragraph (1) or (9) of section 1862(a), but only if (i) such individual was without fault in incurring such expenses and (ii) the Secretary's determination that such payment may not be made for such items and services was made after the third year following the year in which notice of such payment was sent to such individual, except that the

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P.L. 97-248, §122(g)(4), struck out "or (o)" and substituted "(o), or (dd)". For the effective date, see P.L. 97-248, "Tax Equity and Fiscal Responsibility Act of 1982", §122(h)(1).

P.L. 97-248, §128(d)(3), struck out "an institution" and substituted "a hospital", effective September 3, 1982.

P.L. 97-248, §128(d)(3), struck out "such institution" and substituted "the hospital", effective September 3, 1982.

See P.L. 97-248, "Tax Equity and Fiscal Responsibility Act of 1982", §119, with respect to private sector review initiative and restriction against recovery from beneficiaries.

P.L. 97-248, §144(1), struck out "and", effective September 3, 1982.

P.L. 97-248, §128(d)(4), inserted "of section 1862(a)", effective September 3, 1982.

Continued Section 1866(a) of the Act

Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this title,[1]

(C) to make adequate provision for return (or other disposition, in accordance with regulations) of any moneys incorrectly collected from such individual or other person,[2]

(D) to promptly notify the Secretary of its employment of an individual who, at any time during the year preceding such employment, was employed in a managerial, accounting, auditing, or similar capacity (as determined by the Secretary by regulation) by an agency or organization which serves as a fiscal intermediary or carrier (for purposes of part A or part B, or both, of this title) with respect to the provider,[3]

(E) to release data with respect to patients of such provider upon request to an organization having a contract with the Secretary under part B of title XI as may be necessary (i) to allow such organization to carry out its functions under such contract, or (ii) to allow such organization to carry out similar review functions under any contract the organization may have with a private or public agency paying for health care in the same area with respect to patients who authorize release of such data for such purposes[4] [5]

(F) in the case of hospitals which provide inpatient hospital services for which payment may be made under subsection (c) or (d) of section 1886, to maintain an agreement with a utilization and quality control peer review organization (with[6] an organization which has a contract with the Secretary under part B of title XI for the area in which the hospital is located) under which the organization will perform functions under that part with respect to the review of the validity of diagnostic information provided by such hospital, the completeness, adequacy, and quality of care provided, the appropriateness of admissions and discharges, and the appropriateness of care provided for which additional payments are sought under section 1886(d)(5), with respect to inpatient hospital services for which payment may be made under part A of this title (and for purposes of payment under this title, the cost of such agreement to the hospital shall be considered a cost incurred by such hospital in providing inpatient services under part A, and (i) shall be paid directly by the Secretary to such organization on behalf of such hospital in accordance with a rate per review established by the Secretary, (ii) shall be transferred from the Federal Hospital Insur-

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[1] P.L. 97-248, §144(1), struck out "and", effective September 3, 1982.

[2] P.L. 97-248, §144(1), struck out "and", effective September 3, 1982.

[3] P.L. 98-21, §602(f)(1)(A), struck out "and", effective October 1, 1983.

[4] P.L. 98-21, §602(f)(1)(B), struck out the period at the end of subparagraph (E). A comma should be inserted.

[5] P.L. 97-248, §144(3), added subparagraph (E), effective, subject to §150, with respect to contracts entered into or renewed on or after September 3, 1982. For P.L. 97-248, "Tax Equity and Fiscal Responsibility Act of 1982", §150.

[6] P.L. 98-21, §602(f)(1), struck out "(if there is such" and substituted "(with", effective October 1, 1984.

continued
Section 1866(a)
of the Act

ance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, (iii) shall be not less than an amount which reflects the rates per review established in fiscal year 1982 for both direct and administrative costs (adjusted for inflation), and (iv) shall not be less in the aggregate for a fiscal year than the aggregate amount expended in fiscal year 1982 for direct and administrative costs (adjusted for inflation)) of such reviews,[1]

(G) in the case of hospitals which provide inpatient hospital services for which payment may be made under subsection (b) or (d) of section 1886, not to charge any individual or any other person for inpatient hospital services for which such individual would be entitled to have payment made under part A but for a denial or reduction of payments under section 1886(f)(2), and[2]

(H) in the case of hospitals which provide inpatient hospital services for which payment may be made under this title, to have all items and services (other than physicians' services as defined in regulations for purposes of section 1862(a)(14)) (i) that are furnished to an individual who is an inpatient of the hospital, and (ii) for which the individual is entitled to have payment made under this title, furnished by the hospital or otherwise under arrangements (as defined in section 1861(w)(1)) made by the hospital.[3] [4]

[5] In the case of a hospital which has an agreement in effect with an organization described in subparagraph (F), which organization's contract with the Secretary under part B of title XI is terminated on or after October 1, 1984, the hospital shall not be determined to be out of compliance with the requirement of such subparagraph during the six month period beginning on the date of the termination of that contract.[6]

(2)(A) A provider of services may charge such individual or other person (i) the amount of any deduction or coinsurance amount imposed pursuant to section 1813(a)(1),[7] (a)(3), or (a)(4)[8], section 1833(b), or

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[1] P.L. 98-21, §602(f)(1)(C), added subparagraph (F), effective October 1, 1983.

[2] P.L. 98-21, §602(f)(1)(C), added subparagraph (G), effective October 1, 1983.

[3] P.L. 98-21, §602(f)(1)(C), added subparagraph (H), effective October 1, 1983.

[4] See P.L. 98-21, "Social Security Amendments of 1983", §602(k), with respect to certain conditions under which the Secretary may waive the requirements of this provision.

[5] P.L. 97-35, §2153, struck out the second sentence of paragraph (1) of subsection (a), which read as follows: "An agreement under this paragraph with a skilled nursing facility shall be for a term of not exceeding 12 months, except that the Secretary may extend such term for a period not exceeding 2 months, where the health and safety of patients will not be jeopardized thereby, if he finds that such extension is necessary to prevent irreparable harm to such facility or hardship to the individuals being furnished items or services by such facility or if he finds it impracticable within such 12-month period to determine whether such facility is complying with the provisions of this title and regulations thereunder.", effective August 13, 1981.

[6] P.L. 98-21, §602(i)(2), added the preceding sentence to paragraph (1), effective October 1, 1984.

[7] P.L. 97-448, §309(b)(11), inserted ",", effective as if it had been included originally in P.L. 97-248. For the effective date, see P.L. 97-248, "Tax Equity and Fiscal Responsibility Act of 1982", §122(h)(1).

[8] P.L. 97-248, §122(g)(5), struck out "or (a)(3)" from §1866(b)(2)(A) and substituted "(a)(3), or (a)(4)". For the effective date, see P.L. 97-248, "Tax Equity and Fiscal Responsibility Act of 1982", §122(h)(1).

P.L. 97-448, §309(a)(5), amended P.L. 97-248, §122(g)(5), by striking out "1866(b)(2)(A)" and

Exhibit B, page 16.4

continued
Section 1866(a)
of the Act

section 1861(y)(3) with respect to such items and services (not in excess of the amount customarily charged for such items and services by such provider), and (ii) an amount equal to 20 per centum of the reasonable charges for such items and services (not in excess of 20 per centum of the amount customarily charged for such items and services by such provider) for which payment is made under part B (but in the case of items and services furnished to individuals with end-stage renal disease, an amount equal to 20 percent of the estimated amounts for such items and services calculated on the basis established by the Secretary). In the case of items and services described in section 1833(c), clause (ii) of the preceding sentence shall be applied by substituting for 20 percent the proportion which is appropriate under such section. A provider of services may not impose a charge under clause (ii) of the first sentence of this subparagraph with respect to items and services described in section 1861(s)(10) for which payment is made under part B.[1]

(B)(i) Where a provider of services has furnished, at the request of such individual, items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under this title, such provider of services may also charge such individual or other person for such more expensive items or services to the extent that the amount customarily charged by it for the items or services furnished at such request exceeds the amount customarily charged by it for the items or services with respect to which payment may be made under this title.

(ii) Where a provider of services customarily furnishes an individual items or services which are more expensive than the items or services determined to be necessary in the efficient delivery of needed health services under this title and which have not been requested by such individual, such provider may (except with respect to emergency services and except with respect to inpatient hospital costs with respect to which amounts are payable under section 1886(d)[2]) also charge such individual or other person for such more expensive items or services to the extent that the costs of (or, if less, the customary charges for) such more expensive items or services experienced by such provider in the second fiscal period immediately preceding the fiscal period in which such charges are imposed exceed the cost of such items or services determined to be necessary in the efficient delivery of needed health services, but only if—

(I) the Secretary has provided notice to the public of any charges being imposed on individuals entitled to benefits under this title on account of costs in excess of the costs determined to be necessary in the efficient delivery of needed health services under this title by

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substituting "1866(a)(2)(A)", effective as if it had been included originally in P.L. 97-248.

[1] P.L. 96-611, §1(b)(4), added the preceding sentence, effective on, and applicable to services furnished on or after, July 1, 1981.

[2] P.L. 98-21, §602(f)(2), inserted "and except with respect to inpatient hospital costs with respect to which amounts are payable under section 1886(d)", effective with respect to items and services furnished by or under arrangements with a hospital beginning with its first cost reporting period that begins on or after October 1, 1983.

continued
Section 1866(a)
of the Act

particular providers of services in the area in which such items or services are furnished, and

(II) the provider of services has identified such charges to such individual or other person, in such manner as the Secretary may prescribe, as charges to meet costs in excess of the cost determined to be necessary in the efficient delivery of needed health services under this title.

(C) A provider of services may in accordance with its customary practice also appropriately charge any such individual for any whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished him with respect to which a deductible is imposed under section 1813(a)(2), except that (i) any excess of such charge over the cost to such provider for the blood (or equivalent quantities of packed red blood cells, as so defined) shall be deducted from any payment to such provider under this title, (ii) no such charge may be imposed for the cost of administration of such blood (or equivalent quantities of packed red blood cells, as so defined), and (iii) such charge may not be made to the extent such blood (or equivalent quantities of packed red blood cells, as so defined) has been replaced on behalf of such individual or arrangements have been made for its replacement on his behalf. For purposes of subparagraph (C), whole blood (or equivalent quantities of packed red blood cells, as so defined) furnished an individual shall be deemed replaced when the provider of services is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is imposed under section 1813(a)(2).

(D) Where a provider of services customarily furnishes items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under this title, such provider, notwithstanding the preceding provisions of this paragraph, may not, under the authority of section 1866(a)(2)(B)(ii), charge any individual or other person any amount for such items or services in excess of the amount of the payment which may otherwise be made for such items or services under this title if the admitting physician has a direct or indirect financial interest in such provider.

(3) The Secretary may refuse to enter into or renew an agreement under this section with a provider of services if any person who has a direct or indirect ownership or control interest of 5 percent or more in such provider, or who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of such provider, is a person described in section 1126(a).

Section 1866(b)
of The Act

(b) An agreement with the Secretary under this section may be terminated[1] —

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[1] P.L. 97-248, §128(a)(5) struck out "(and in the case of a skilled nursing facility, prior to the end of the term specified in subsection (a)(1))". For the effective date, see P.L. 97-248, "Tax Equity and Fiscal Responsibility Act of 1982", §128(e)(2).

Exhibit B, page 16.6

continued
Section 1866(b)
of the Act.

(1) by the provider of services at such time and upon such notice to the Secretary and the public as may be provided in regulations, except that notice of more than 6 months shall not be required, or

(2) by the Secretary at such time and upon such reasonable notice to the provider of services and the public as may be specified in regulations, but only after the Secretary has determined (A) that such provider of services is not complying substantially with the provisions of such agreement, or with the provisions of this title and regulations thereunder, or (B) that such provider of services no longer substantially meets the applicable provisions of section 1861, or (C) that such provider of services has failed (i) to provide such information as the Secretary finds necessary to determine whether payments are or were due under this title and the amounts thereof, or has refused to permit such examination of its fiscal and other records by or on behalf of the Secretary as may be necessary to verify such information, or (ii) to supply (within such period as may be specified by the Secretary in regulations) upon request specifically addressed to such provider by the Secretary (I) full and complete information as to the ownership of a subcontractor (as defined by the Secretary in regulations) with whom such provider has had, during the previous twelve months, business transactions in an aggregate amount in excess of $25,000, and (II) full and complete information as to any significant business transactions (as defined by the Secretary in regulations), occurring during the five-year period ending on the date of such request, between such provider and any wholly owned supplier or between such provider and any subcontractor, or (D) that such provider has made, or caused to be made, any false statement or representation of a material fact for use in an application for payment under this title or for use in determining the right to a payment under this title, or (E) that such provider has submitted, or caused to be submitted, requests for payment under this title of amounts for rendering services substantially in excess of the costs incurred by such provider for rendering such services, or (F) that such provider has furnished services or supplies which are determined by the Secretary to be substantially in excess of the needs of individuals or to be of a quality which fails to meet professionally recognized standards of health care, or (G) that such provider (at the time the agreement was entered into) did not fully and accurately make any disclosure required of it by section 1126(a).

Any termination shall be applicable—

(3) in the case of inpatient hospital services (including tuberculosis hospital services and inpatient psychiatric hospital services) or post-hospital extended care services, with respect to services furnished after the effective date of such termination, except that payment may be made for up to thirty days with respect to inpatient institutional services furnished to any eligible individual who was admitted to such institution prior to the effective date

. . .

Exhibit C, page 17

(27) provide for agreements with every person or institution providing services under the State plan under which such person or institution agrees (A) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan, and (B) to furnish the State agency or the Secretary with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency or the Secretary may from time to time request;

Section 1902(a)(27) of the Act

(28) provide that any skilled nursing facility receiving payments under such plan must satisfy all of the requirements contained in section 1861(j), except that the exclusion contained therein with respect to institutions which are primarily for the care and treatment of mental diseases and tuberculosis shall not apply for purposes of this title;

Section 1902(a)(28) of the Act

Exhibit D, page 18

Section 1902(a)(33) of the Act

(33) provide—

(A) that the State health agency, or other appropriate State medical agency, shall be responsible for establishing a plan, consistent with regulations prescribed by the Secretary, for the review by appropriate professional health personnel of the appropriateness and quality of care and services furnished to recipients of medical assistance under the plan in order to provide guidance with respect thereto in the administration of the plan to the State agency established or designated pursuant to paragraph (5) and, where applicable, to the State agency described in the penultimate sentence of this subsection, and

(B) that the State or local agency utilized by the Secretary for the purpose specified in the first sentence of section 1864(a), or, if such agency is not the State agency which is responsible for licensing health institutions, the State agency responsible for such licensing, will perform for the State agency administering or supervising the administration of the plan approved under this title the function of determining whether institutions and agencies meet the requirements for participation in the program under such plan, except that, if the Secretary has cause to question the adequacy of such determinations, the Secretary is authorized to validate State determinations and, on that basis, make independent and binding determinations concerning the extent to which individual institutions and agencies meet the requirements for participation,

Added by Section 916(b)(2) ORA-80

Exhibit E, page 19

PAYMENT TO STATES

Section 1903(a) of the Act

SEC. 1903. [42 U.S.C. 1396b] (a) From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing January 1, 1966—

(1) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b), subject to subsections (g), (h), and (j) of this section) of the total amount expended during such quarter as medical assistance under the State plan (including expenditures for premiums under part B of title XVIII, for individuals who are eligible for medical assistance under the plan and (A) are receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI, or (B) with respect to whom there is being paid a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A), and, except in the case of individuals sixty-five years of age or older and disabled individuals entitled to hospital insurance benefits under title XVIII who are not enrolled under part B of title XVIII, other insurance premiums for medical or any other type of remedial care or the cost thereof); plus

(2) an amount equal to 75 per centum of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to compensation or training of skilled professional medical personnel, and staff directly supporting such personnel, of the State agency or any other public agency; plus

(3) an amount equal to—

(A)(i) 90 per centum of so much of the sums expended during such quarter as are attributable to the design, development, or installation of such mechanized claims processing and information retrieval systems as the Secretary determines are likely to provide more efficient, economical, and effective administration of the plan and to be compatible with the claims processing and information retrieval systems utilized in the administration of title XVIII, including the State's share of the cost of installing such a system to be used jointly in the administration of such State's plan and the plan of any other State approved under this title, and

(ii) 90 per centum of so much of the sums expended during any such quarter in the fiscal year ending June 30, 1972, or the fiscal year ending June 30, 1973, as are attributable to the design, development, or installation of cost determination systems for State-owned general hospitals (except that the total amount paid to all States under this clause for either such fiscal year shall not exceed $150,000), and

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As in original. Possibly should be "subparagraph".

P.L. 97-248, §132(c), struck out the former subsection (j), effective September 3, 1982, but the provisions of §1917(c)(2)(B) of the Act shall not apply with respect to a transfer of assets which took place prior to September 3, 1982.

P.L. 97-248, §134(d), added this subsection (j), effective October 1, 1982.

See P.L. 97-248, "Tax Equity and Fiscal Responsibility Act of 1982", §133(c), with respect to limiting Federal financial participation.

continued
Section 1903(a)
of the Act

(B) 75 per centum of so much of the sums expended during such quarter as are attributable to the operation of systems (whether such systems are operated directly by the State or by another person under a contract with the State) of the type described in subparagraph (A)(i) (whether or not designed, developed, or installed with assistance under such subparagraph) which are approved by the Secretary and which include provision for prompt written notice to each individual who is furnished services covered by the plan, or to each individual in a sample group of individuals who are furnished such services, of the specific services (other than confidential services) so covered, the name of the person or persons furnishing the services, the date or dates on which the services were furnished, and the amount of the payment or payments made under the plan on account of the services, and[1]

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[1] P.L. 97-35, §2113(a)(1), struck out "plus" and substituted "and", effective with respect to agreements with Professional Standards Review Organizations entered into on or after October 1, 1981

(C) 75 per centum of the sums expended with respect to costs incurred during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to the performance of medical and utilization review by a utilization and quality control peer review organization[1] under a contract entered into under section 1902(d); plus[2]

[(4) Expired.[4]]

(5) an amount equal to 90 per centum of the sums expended during such quarter which are attributable to the offering, arranging, and furnishing (directly or on a contract basis) of family planning services and supplies;

(6) subject to subsection (b)(3), an amount equal to—

(A) 90 per centum of the sums expended during such a quarter within the twelve-quarter period beginning with the first quarter in which a payment is made to the State pursuant to this paragraph, and

(B) 75 per centum of the sums expended during each succeeding calendar quarter,

with respect to costs incurred during such quarter (as found necessary by the Secretary for the elimination of fraud in the provision and administration of medical assistance provided under the State plan) which are attributable to the establishment and operation of (including the training of personnel employed by) a State medicaid fraud control unit (described in subsection (q)); plus

(7) an amount equal to 50 per centum of the remainder of the amounts expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.

Section 1905(c) of the Act

(c) For purposes of this title the term "intermediate care facility" means an institution which (1) is licensed under State law to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities, (2) meets such standards prescribed by the Secretary as he finds appropriate for the proper provision of such care, (3) meets such standards of safety and sanitation as are established under regulation of the Secretary in addition to those applicable to nursing homes[3] under State law; and (4) meets the requirements of section 1861(j)(14) with respect to protection of patients' personal funds. The term "intermediate care facility" also includes any skilled nursing facility or hospital which meets the requirements of the preceding sentence. The term "intermediate care facility" also includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts, but only with respect to institutional services deemed appropriate by the State. The term "intermediate care facility" also includes any institution which is located in a State on an Indian reservation and is certified by the Secretary as meeting the requirements of clauses (2), (3), and (4) of this subsection and providing the care and services required under clause (1). With respect to services furnished to individuals under age 65, the term "intermediate care facility" shall not include, except as provided in subsection (d), any public institution or distinct part thereof for mental diseases or mental defects.[4]

Section 1905(d) of the Act

(d) The term "intermediate care facility services" may include services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions if—

(1) the primary purpose of such institution (or distinct part thereof) is to provide health or rehabilitative services for mentally retarded individuals and which meet such standards as may be prescribed by the Secretary;

(2) the mentally retarded individual with respect to whom a request for payment is made under a plan approved under this title is receiving active treatment under such a program; and

(3) the State or political subdivision responsible for the operation of such institution has agreed that the non-Federal expenditures in any calendar quarter prior to January 1, 1975, with respect to services furnished to patients in such institution (or distinct part thereof) in the State will not, because of payments made under this title, be reduced below the average amount expended for such services in such institution in the four quarters immediately preceding the quarter in which the State in which such institution is located elected to make such services available under its plan approved under this title.

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[1] P.L. 96-437.

[2] See P.L. 97-35, §2163, with respect to a study by the Comptroller General of the matching formula.

[3] Questionable term in law. Should probably be "facilities"

[4] See P.L. 95-292 [Social Security-End Stage Renal Disease Program], §4(c), with respect to sums chargeable to patients' funds.

Exhibit F, page 20.1

(f) For purposes of this title, the term "skilled nursing facility services" means services which are or were required to be given an individual who needs or needed on a daily basis skilled nursing care (provided directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis.

Section 1905 (f)
of the Act

(i) For purposes of this title, the term "skilled nursing facility" also includes any institution which is located in a State on an Indian reservation and is certified by the Secretary as being a qualified skilled nursing facility by meeting the requirements of section 1861(j).

Section 1905(i)
of the Act

CERTIFICATION AND APPROVAL OF SKILLED NURSING FACILITIES AND OF RURAL HEALTH CLINICS[1]

Section 1910(a)
of the Act

SEC. 1910. [42 U.S.C. 1396i] (a)(1) Whenever the Secretary certifies an institution in a State to be qualified as a skilled nursing facility under title XVIII, such institution shall be deemed to meet the standards for certification as a skilled nursing facility for purposes of section 1902(a)(28).

(2) The Secretary shall notify the State agency administering the medical assistance plan of his approval or disapproval of any institution which has applied for certification by him as a qualified skilled nursing facility.

(b)(1) Whenever the Secretary certifies a facility in a State to be qualified as a rural health clinic under title XVIII, such facility shall be deemed to meet the standards for certification as a rural health clinic for purposes of providing rural health clinic services under this title.

(2) The Secretary shall notify the State agency administering the medical assistance plan of his approval or disapproval of any facility in that State which has applied for certification by him as a qualified rural health clinic.

Section 1910(c)
of the Act
Added by ORA-80

(c)(1) The Secretary may cancel approval of any skilled nursing or intermediate care facility at any time if he finds on the basis of a determination made by him as provided in section 1902(a)(33)(B) that a facility fails to meet the requirements contained in section 1902(a)(28) or section 1905(c), or if he finds grounds for termination of his agreement with the facility pursuant to section 1866(b). In that event the Secretary shall notify the State agency and the skilled nursing facility or intermediate care facility that approval of eligibility of the facility to participate in the programs established by this title and title XVIII shall be terminated at a time specified by the Secretary. The approval of eligibility of any such facility to participate in such programs may not be reinstated unless the Secretary finds that the reason for termination has been removed and there is reasonable assurance that it will not recur.

(2) Any skilled nursing facility or intermediate care facility which is dissatisfied with a determination by the Secretary that it no longer qualifies as a skilled nursing facility or intermediate care facility for purposes of this title, shall be entitled to a hearing by the Secretary to the same extent as is provided in section 205(b) and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g). Any agreement between such facility and the State agency shall remain in effect until the period for filing a request for a hearing has expired or, if a request has been filed, until a decision has been made by the Secretary; except that the agreement shall not be extended if the Secretary makes a written determination, specifying the reasons therefor, that the continuation of provider status constitutes an immediate and serious threat to the health and safety of patients, and the Secretary certifies that the facility has been notified of its deficiencies and has failed to correct them.

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[1] See P.L. 95-210, [Social Security-Rural Health Clinic Services], §1(a), with respect to rural health clinics.

ALTERNATIVE TO DECERTIFICATION OF LONG-TERM CARE FACILITIES OUT OF COMPLIANCE WITH CONDITIONS OF PARTICIPATION; LOOK BEHIND AUTHORITY

§916(a) of ORA-80 (adds §1866(f) to the Act)

SEC. 916. (a) Section 1866 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(f)(1) Where the Secretary determines that a skilled nursing facility which has filed an agreement pursuant to subsection (a)(1) or which has been certified for participation in a plan approved under title XIX no longer substantially meets the provisions of section 1861(j), and further determines that the facility's deficiencies—

"(A) immediately jeopardize the health and safety of its patients, the Secretary shall provide for the termination of the agreement or of the certification of the facility and shall provide, or

"(B) do not immediately jeopardize the health and safety of its patients, the Secretary may, in lieu of terminating the agreement or certification of the facility, provide

that no payment shall be made under this title (and order a State agency established or designated pursuant to section 1902(a)(5) of this Act to administer or supervise the administration of the State plan under title XIX of this Act to deny payment under such title XIX) with respect to any individual admitted to such facility after a date specified by him.

"(2) The Secretary shall not make such a decision with respect to a facility until such facility has had a reasonable opportunity, following the initial determination that it no longer substantially meets the provisions of section 1861(j), to correct its deficiencies, and, following this period, has been given reasonable notice and opportunity for a hearing.

"(3) The Secretary's decision to deny payment may be made effective only after such notice to the public and to the facility as may be prescribed in regulations, and its effectiveness shall terminate (A) when the Secretary finds that the facility is in substantial compliance (or is making good faith efforts to achieve substantial compliance) with the provisions of section 1861(j), or (B) in the case described in paragraph (1)(B), with the end of the eleventh month following the month such decision is made effective, whichever occurs first. If a facility to which clause (B) of the previous sentence applies still fails to substantially meet the provisions of section 1861(j) on the date specified in such clause, the Secretary shall terminate such facility's agreement or provide for termination of such facility's certification, notwithstanding the provisions of paragraph (2) of subsection (b), effective with the first day of the first month following the month specified in such clause.".

(b)(1)(A) Section 1902 of such Act is amended by adding after subsection (h) (added by section 902(b)(2) of this title) the following new subsection:

§916(b)(1)(A) of ORA-1980 (adds §1902(i) of the Act)

"(i)(1) In addition to any other authority under State law, where a State determines that a skilled nursing facility or intermediate care facility which is certified for participation under its plan no longer substantially meets the provisions of section 1861(j) or section 1905(c), respectively, and further determines that the facility's deficiencies—

"(A) immediately jeopardize the health and safety of its patients, the State shall provide for the termination of the facility's certification for participation under the plan and may provide, or

"(B) do not immediately jeopardize the health and safety of its patients, the State may, in lieu of providing for terminating the facility's certification for participation under the plan, provide that no payment will be made under the State plan with respect to any individual admitted to such facility after a date specified by the State.

"(2) The State shall not make such a decision with respect to a facility until the facility has had a reasonable opportunity, following the initial determination that it no longer substantially meets the provisions of section 1861(j) or section 1905(c) (as the case may be), to correct its deficiencies, and, following this period, has been given reasonable notice and opportunity for a hearing.

"(3) The State's decision to deny payment may be made effective only after such notice to the public and to the facility as may be provided for by the State, and its effectiveness shall terminate (A) when the State finds that the facility is in substantial compliance (or is making good faith efforts to achieve substantial compliance) with the provisions of section 1861(j) or section 1905(c) (as the case may be), or (B) in the case described in paragraph (1)(B), with the end of the eleventh month following the month such decision is made effective, whichever occurs first. If a facility to which clause (B) of the previous sentence applies still fails to substantially meet the provisions of the respective section on the date specified in such clause, the State shall terminate such facility's certification for participation under the plan effective with the first day of the first month following the month specified in such clause.".

(B) Such section is further amended by inserting before the semicolon at the end of subsection (a)(33)(B) the following: ", except that, if the Secretary has cause to question the adequacy of such determinations, the Secretary is authorized to validate State determinations and, on that basis, make independent and binding determinations concerning the extent to which individual institutions and agencies meet the requirements for participation".

§916(b)(1)(B) of ORA-1980 (amends §1902(a)(33)(B) of the Act)

Exhibit H, page 22.2

§916(b)(2) of ORA-1980
(adds §1910(c)
of the Act

(2) Section 1910 of such Act is amended by adding at the end thereof the following new subsection:

"(c)(1) The Secretary may cancel approval of any skilled nursing or intermediate care facility at any time if he finds on the basis of a determination made by him as provided in section 1902(a)(33)(B) that a facility fails to meet the requirements contained in section 1902(a)(28) or section 1905(c), or if he finds grounds for termination of his agreement with the facility pursuant to section 1866(b). In that event the Secretary shall notify the State agency and the skilled nursing facility or intermediate care facility that approval of eligibility of the facility to participate in the programs established by this title and title XVIII shall be terminated at a time specified by the Secretary. The approval of eligibility of any such facility to participate in such programs may not be reinstated unless the Secretary finds that the reason for termination has been removed and there is reasonable assurance that it will not recur.

"(2) Any skilled nursing facility or intermediate care facility which is dissatisfied with a determination by the Secretary that it no longer qualifies as a skilled nursing facility or intermediate care facility for purposes of this title, shall be entitled to a hearing by the Secretary to the same extent as is provided in section 205(b) and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g). Any agreement between such facility and the State agency shall remain in effect until the period for filing a request for a hearing has expired or, if a request has been filed, until a decision has been made by the Secretary; except that the agreement shall not be extended if the Secretary makes a written determination, specifying the reasons therefor, that the continuation of provider status constitutes an immediate and serious threat to the health and safety of patients, and the Secretary certifies that the facility has been notified of its deficiencies and has failed to correct them.".

42 CFR PART 431

Subpart D—Appeals Process for SNF's and ICF's

SOURCE: 44 FR 9753, Feb. 15, 1979, unless otherwise noted.

§ 431.151 Scope and applicability.

This subpart specifies the appeal procedures the State must make available to a skilled nursing facility (SNF) or intermediate care facility (ICF) for which the State denies, terminates, or fails to renew certification or a provider agreement for the Medicaid program.

§ 431.152 State plan requirements.

The State plan must provide for appeals procedures that, as a minimum, satisfy the requirements of §§ 431.153 through 431.155.

§ 431.153 Evidentiary hearing.

(a) Except as specified in paragraph (d) of this section, any SNF or ICF whose certification or provider agreement is denied, terminated, or not renewed must be given an opportunity for a full evidentiary hearing on the denial, termination or nonrenewal.

(b) If the facility requests a hearing, it must be completed either before the effective date of the denial, termination or nonrenewal or within 120 days after that date.

(c) The hearing must, at a minimum, include—

(1) Timely written notice to the facility of the basis for the decision and disclosure of the evidence on which the decision is taken;

(2) An opportunity for the facility to appear before an impartial decision maker to refute the basis for the decision;

(3) An opportunity for the facility to be represented by counsel or another representative;

(4) An opportunity for the facility or its representatives to be heard in person, to call witnesses, and to present documentary evidence;

(5) An opportunity for the facility to cross-examine witnesses; and

(6) A written decision by the impartial decision maker, setting forth the reasons for the decision and the evidence upon which the decision is based.

(d) If a SNF is participating, or seeking to participate, in both Medicare and Medicaid, and if the basis for the State's denial, termination or nonrenewal of participation in Medicaid is also a basis for denial, termination or nonrenewal of participation in Medicare, the State must advise the facility that—

(1) The facility is entitled to the review procedures specified for Medicare facilities in Part 405, Subpart O of this title, in lieu of the procedures specified in this subpart; and

(2) A final decision entered under the Medicare review procedures will be binding for purposes of Medicaid participation.

§ 431.154 Informal reconsideration.

(a) If the State decides to provide the opportunity for an evidentiary hearing required by § 431.153 only after the effective date of a denial, termination or nonrenewal, the State must offer the facility an informal reconsideration, to be completed before the effective date.

(b) The informal reconsideration must, at a minimum, include—

(1) Written notice to the facility of the denial, termination or nonrenewal and the findings upon which it was based;

(2) A reasonable opportunity for the facility to refute those findings in writing, and

(3) A written affirmation or reversal of the denial, termination, or nonrenewal

42 CFR 441.11

§ 441.11 Continuation of FFP for institutional services.

(a) If a Medicaid agency terminates or fails to renew a provider agreement for the services specified in paragraph (c) of this section because the services no longer meet the applicable definitions, FFP may be continued for a period specified in paragraph (b) of this section, only—

(1) For payment for individuals admitted to the facility before the provider agreement terminated or was not renewed; and

(2) If the agency makes reasonable efforts to transfer the individuals to another facility or to alternate care.

(b) FFP may be continued under the conditions specified in paragraph (a) of this section, for no more than 30 days from—

(1) The termination or expiration date by HCFA of the facility's provider agreement under Medicare;

(2) The termination or expiration date by the agency of its provider agreement; or

(3) For a facility or program providing inpatient psychiatric services for individuals under age 21, the earlier of either—

(i) The effective date of its loss of accreditation by the Joint Commission on Accreditation of Hospitals; or

(ii) The termination by the agency of its provider agreement.

(c) FFP may be continued, as specified in this section, for the following services:

(1) Inpatient hospital services as defined in § 440.10 of this subchapter.

(2) Inpatient hospital services for individuals age 65 or older in an institution for tuberculosis or mental diseases, as defined in § 440.140 of this subchapter.

(3) Skilled nursing facility services for individuals age 21 or older, as defined in § 440.40(a) of this subchapter.

(4) Skilled nursing facility services for individuals age 65 or older in an institution for tuberculosis or mental diseases, as defined in § 440.140 of this subchapter.

(5) Intermediate care facility services, as defined in § 440.150 of this subchapter

(6) Intermediate care facility services for individuals age 65 or older in an institution for tuberculosis or mental diseases, as defined in § 440.140 of this subchapter.

(7) Inpatient psychiatric services for individuals under age 21, as defined in § 440.160 of this subchapter.

Exhibit K, page 25

Subpart B—Provider Agreements

§ 442.10 State plan requirement.

A State plan must provide that requirements of this subpart are met.

§ 442.12 Provider agreement: General requirements.

(a) *Certification and recertification.* Except as provided in paragraph (b) of this section, a Medicaid agency may not execute a provider agreement with a facility for SNF or ICF services nor make Medicaid payments to a facility for those services unless the Secretary or the State survey agency has certified the facility under this part to provide those services. (See § 442.101 for certification by the Secretary or by the State survey agency).

(b) *Exception.* The certification requirement of paragraph (a) of this section does not apply with respect to Christian Science sanitoria operated, or listed and certified, by the First Church of Christ Scientist, Boston, Mass.

(c) *Conformance with certification condition.* An agreement must be in accordance with the certification provisions set by the Secretary or the survey agency under Subpart C of this part.

(d) *Denial for good cause.* (1) If the Medicaid agency has adequate documentation showing good cause, it may refuse to execute an agreement, or may cancel an agreement, with a certified facility.

(2) A provider agreement is not a valid agreement for purposes of this part even though certified by the State survey agency, if the facility fails to meet the civil rights requirements set forth in 45 CFR Parts 80, 84, and 90.

[45 FR 22936, Apr. 4, 1980]

← 42CFR 442.12

42CFR 442.13 -.14

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§ 442.13 Effective date of agreement.

(a) *Basic requirements.* If the Medicaid agency enters into a provider agreement, the effective date must be in accordance with this section.

(b) *All Federal requirements are met on the date of the survey.* The agreement must be effective on the date the onsite survey is completed (or on the day following the expiration of a current agreement) if, on the date of the survey, the provider meets:

(1) All Federal health and safety standards; and

(2) Any other requirements imposed by the Medicaid agency.

(c) *All Federal requirements are not met on the date of the survey.* If the provider fails to meet any of the requirements specified in paragraph (b) of this section, the agreement must be effective on the earlier of the following dates:

(1) The date on which the provider meets all requirements.

(2) The date on which the provider submits a correction plan acceptable to the State survey agency or an approvable waiver request, or both.

[45 FR 22936, Apr. 4, 1980]

§ 442.14 Effect of change of ownership.

(a) *Assignment of agreement.* When there is a change of ownership, the Medicaid agency must automatically assign the agreement to the new owner.

(b) *Conditions that apply to assigned agreements.* An assigned agreement is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued, including, but not limited to, the following:

(1) Any existing plan of correction.

(2) Any expiration date.

(3) Compliance with applicable health and safety standards.

(4) Compliance with the ownership and financial interest disclosure requirements of §§ 455.104 and 455.105 of this chapter.

(5) Compliance with civil rights requirements set forth in 45 CFR Parts 80, 84, and 90.

(6) Compliance with any additional requirements imposed by the Medicaid agency.

[45 FR 22936, Apr. 4, 1980]

42CFR 442.15

§ 442.15 Duration of agreement.

(a) Except as specified under § 442.16, the duration of an agreement may not exceed 12 months.

(b) The agreement must be for the same duration as the certification period set by the survey agency. However, if the Medicaid agency has adequate documentation showing good cause, it may make an agreement for less than this period.

(c) FFP is available for services provided by a facility for up to 30 days after its agreement expires or terminates under the conditions specified in § 441.11 of this subchapter.

(d) The limitation specified in paragraph (a) of this section does not apply to hospitals with a swing-bed approval.

[43 FR 45233, Sept. 29, 1978, as amended at 47 FR 31532, July 20, 1982]

42CFR 442.16

§ 442.16 Extension of agreement.

A Medicaid agency may extend a provider agreement for up to 2 months beyond its original expiration date if it receives written notice from the survey agency, before the expiration date of the agreement, that extension will not jeopardize the patients' health and safety, and—

(a) Is needed to prevent irreparable harm to the facility or hardship to the recipients in the facility; or

(b) Is needed because it is impracticable to determine, before the expiration date, whether the facility meets certification standards.

42CFR 442.30

§ 442.30 Agreement as evidence of certification.

(a) Under §§ 440.40(a) and 440.150 of this subchapter, FFP is available in expenditures for SNF and ICF service only if the facility has been certified as meeting the requirements for Medicaid participation, as evidenced by a provider agreement executed under this part. An agreement is not valid evidence that a facility has met those requirements if the Administrator determines that—

(1) The survey agency failed to apply the applicable certification standards required under Subpart D, E, F, or G of this part;

(2) The survey agency failed to follow the rules and procedures for certification set forth in Subpart C of this part and § 431.610 of this subchapter;

(3) The survey agency failed to perform any of the functions specified in § 431.610(g) of this subchapter relating to evaluating and acting on information about the facility and inspecting the facility;

(4) The survey agency failed to use the Federal standards and the forms, methods, and procedures required under § 431.610(f)(1) for determining qualifications of providers; or

(5) The agreement's terms and conditions do not meet the requirements of this subpart.

(b) The Administrator will make the determination under paragraph (a) of this section through onsite surveys, other Federal reviews, State certification records, or reports he may require from the Medicaid or survey agency.

(c) If the Administrator disallows a State's claim for FFP because of a determination under paragraph (a) of this section, the State is entitled upon request to reconsideration of the disallowance under 45 CFR Part 16.

PART 489—PROVIDER AGREEMENTS UNDER MEDICARE

Subpart A—General Provisions

Sec.
489.1 Statutory basis.
489.2 Scope of part.
489.3 Definition.
489.10 Basic requirements.
489.11 Acceptance of a provider as a participant.
489.12 Decision to deny an agreement.
489.13 Effective date of agreement.
489.15 Time limits on agreements with skilled nursing facilities (SNFs).
489.16 Nonrenewal of agreements with SNFs.

Sec.
489.18 Change of ownership or leasing: Effect on provider agreement.

§ 489.13 Effective date of agreement.

(a) *All Federal requirements are met on the date of the survey.* The agreement will be effective on the date the onsite survey is completed (or on the day following the expiration date of a current agreement) if, on the date of the survey, the provider meets all Federal health and safety standards, and any other requirements imposed by HCFA.

(b) *All Federal requirements are not met on the date of the survey.* If the provider fails to meet any of the requirements specified in paragraph (a) of this section, the agreement will be effective on the earlier of the following dates:

(1) The date on which the provider meets all requirements.

(2) The date on which the provider submits a correction plan acceptable to HCFA or an approvable waiver request, or both.

§ 489.18 Change of ownership or leasing: Effect on provider agreement.

(a) *What constitutes change of ownership*—(1) *Partnership.* In the case of a partnership, the removal, addition, or substitution of a partner, unless the partners expressly agree otherwise, as permitted by applicable State law, constitutes change of ownership.

(2) *Unincorporated sole proprietorship.* Transfer of title and property to another party constitutes change of ownership.

(3) *Corporation.* The merger of the provider corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation constitutes change of ownership. Transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute change of ownership.

(4) *Leasing.* The lease of all or part of a provider facility constitutes change of ownership of the leased portion.

(b) *Notice to HCFA.* A provider who is contemplating or negotiating a change of ownership must notify HCFA.

(c) *Assignment of agreement.* When there is a change of ownership as specified in paragraph (a) of this section, the existing provider agreement will automatically be assigned to the new owner.

(d) *Conditions that apply to assigned agreements.* An assigned agreement is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued including, but not limited to, the following:

(1) Any existing plan of correction.

(2) Any expiration date.

(3) Compliance with applicable health and safety standards.

(4) Compliance with the ownerhsip and financial interest disclosure requirements of Part 420, Subpart C, of this chapter.

(5) Compliance with civil rights requirements set forth in 45 CFR Parts 80, 84, and 90.

(e) *Effect of leasing.* The provider agreement will be assigned to the lessee only to the extent of the leased portion of the facility.

OCT 2 7 1981

Exhibit Q, page 31

Refer To: BPO-P53

Director
Office of Program Administration, BPO

Grant Appeals Board (GAB) Decisions in the Nursing Home Provider Agreements (PAs) Cases--INFORMATION

All Associate Regional Administrators
for Financial Operations

This memorandum should be added to your disallowance training manual. Its purpose is to provide a summary of the provisions of GAB rulings in nursing home "provider agreement" cases.

1. FFP During Provider Appeal

The GAB found that PRG-11 (attached), published on December 20, 1971, remains in effect. The Board decision requires Federal financial participation (FFP) for a longer period than HCFA's interpretation of its policy would otherwise have permitted, but it does not permit States to obtain FFP for indefinite periods of time. The PRG states that FFP is not available to a skilled nursing facility (SNF) whose PA has been terminated, since the facility no longer meets the definition of an SNF. However, the PRG sets forth two exceptions which the Board referred to as Part 1 and Part 2 and cited in their decision 173 as follows:

> ". . . two exceptions to the rule that FFP is not available where a provider agreement has expired and not been renewed or has been terminated:
>
> "(1) [If] State law provides for continued validity of the provider agreement pending appeal [hereinafter referred to as 'Part 1']; or
>
> "(2) [If] the facility is upheld on appeal and State law provides for retroactive reinstatement of the agreement ['Part 2']."

(We will also refer to the exceptions as Part 1 and 2, respectively. In addition, a termination as used in this memorandum includes a nonrenewal. However, it should be noted that some State laws may recognize a distinction between a termination and a nonrenewal which may affect the availability of FFP under the Part 1 exception.)

Our position before the GAB was that PRG-11 was still in effect but that Part 1 was limited by later regulations to a maximum period of 12 months from the start-date of a PA which had later terminated. (The argument that the PRG refers to SNFs only was presented to the Board with no success.) We further stated that in implementing Part 2, we would retroactively reinstate a PA if the facility was upheld on appeal, but that pursuant to other regulations, the reinstated PA could be valid for no longer than the maximum term of 1 year following the termination, absent a new survey establishing compliance. The yearly survey would be required even if the hearing had not been concluded within the 12 months following a termination.

The Board held that we had not shown either that Part 1 was rescinded or that later regulations limited to 12 months the period State law could extend a PA during appeal. However, they stated that a PA continued beyond its termination date by State law (or court order), under Part 1 of PRG-11 could not be valid longer than the next survey cycle. Thus, they applied the same policy to exceptions under Part 1 as we had already applied under Part 2. They stated that a court extension could not give an old agreement greater effect than if the State had approved the facility and made a new agreement.

Thus, in order to continue FFP beyond 1 year under a State law, court order, or a successful appeal by the provider, a new survey within the 12 months after the termination of the old agreement would have to find the facility in compliance, as a State law, court order, or successful appeal by the provider can only reinstate a PA for 1 year "within the scope of the Medicaid program." PRG-11 does not require that FFP continue throughout an appeals process no matter how long that process takes. Therefore, under the Board's decision:

1. FFP is available for up to 12 months after a PA expires either because of nonrenewal or termination, _if_ a State law requires a PA to be continued in effect when a facility appeals the termination (decision 173).

2. If there is no State law to this effect, FFP is not available (decision 87), but see no. 3 below. If State law requires payment during the appeal of a license revocation and not decertification, we will not pay FFP (decision 174).

3. A State court order has the same effect as State Law (decision 173).

4. If the provider does not appeal, FFP is not available (decision 173).

The first requirement is the facility's appeal of the termination (decisions 173 and 187, Page 10, I). It does not appear that an "informal" appeal and the scheduling of revisits by the State survey agency, thus giving the facility more time to come into compliance, would constitute an appeal. In checking the appeal status of the provider, you may want to check the inclusion by the State of the regulations at 42 CFR 431.151 through 431.154 (effective May 16, 1979) in the State plan and how the State implements these required appeal procedures. Certainly, a copy of any State law requiring that the provider be given an appeal should be secured, if at all possible.

When there is no State law providing for the continued validity of the PA pending appeal, the Board has not defined the date at which FFP is mandated by a court order. Clearly the GAB believes FFP must continue after the termination of the PA when the related court order is issued prior to that date. The Board would also hold that FFP is required where the court order is issued after the date of termination, provided that the provider's appeal was filed within a short time after the termination or nonrenewal. Certainly, they indicated (decision 173) that FFP was not required when the record did not show a reason for a delay of many months between the termination and the court order. However, it is not clear at what point the Board will consider an appeal or court order to be so far removed from the termination date that the appeal and order would not require FFP.

For example, assume a PA is terminated December 31, 1980, and a court order staying the termination is issued July 1, 1981, but does not explicitly state that it is retroactive to December 31, 1980. If the provider has appealed the termination within a month after the December 31, 1980 termination, the Board would likely mandate FFP from January 1, 1981. However, if the provider failed to appeal the termination until June 1, 1981, the Board would likely require FFP only from the July 1, 1981 date the court order was issued.

In decision 173, the Board did not require payment of FFP where the record did not establish a connection between the termination and the court order, the lack of connection being emphasized by a considerable lapse of time. HCFA's policy will be to disallow FFP unless the court order is sought within at least the first 30 days after the expiration. Therefore,

(1) If either the appeal under State law or the issuance of a court order occurs within 30 days of the PA termination, we will allow FFP for up to 1 year after the PA expired.

(2) If either the administrative appeal under State law or court hearings are concluded before the end of the year, we would consider those findings to make a determination about further FFP.

(3) Again, if there is no appeal, we do not pay FFP.

(4) If the court order is not issued in the 30 days after the PA

terminates, and no appeal is otherwise in progress under State law, we allow FFP from the date of the court order until 1 year after the PA termination, unless the court order mandates the effective date, but see no. 5 below.

(5) If the appeal is far removed in time from the PA termination, FFP may not be required. For example: If, in a dual facility, the PA for the ICF expired January 31, 1980, and for the SNF on October 31, 1980, but no appeal was filed by the provider until November 1980, we believe the Board is not mandating any FFP beyond January 31, 1980, for the ICF services. (See section II, below.)

(6) If the subsequent annual survey, after a PA termination, occurs while the appeal is still in progress, and the survey agency determines the facility is not certifiable, no further FFP is allowable after the date of the determination of noncompliance, even if this survey comes within the 12 months after termination of the old PA.

This policy will have to be implemented on a case-by-case basis since extenuating circumstances for the tardy appeal could exist.

II. Dual Facility: SNF Service Rendered for Medicare and, SNF and ICF Services Rendered for Medicaid

Under 42 CFR 442.20(a), the State agency must execute the PA for SNF services for Medicaid with the same terms and conditions as the PA for Medicare, if the facility is rendering SNF services for both Medicaid and Medicare. However, for a facility which renders both ICF and SNF services, the responsibility for certifying an ICF (and an SNF which does not render services for Medicare) lies solely with the State (42 CFR 442.12 and 442.101; also see decisions 107 and 189.) The Board has said repeatedly that the State survey agency cannot delay making the certification determination as to ICF services pending HCFA's determination on SNF certification.

III. Effective Date of Certification—Pre and Post July 3, 1980

Pre July 3, 1980

Regulation 42 CFR 442.12(b) [formerly 42 CFR 449.33(a)(6)] provides that the effective date of a PA cannot be earlier than the date of certification. For Medicaid, the State survey agency determines whether the facility has met the requirements for certification and the Secretary, Health and Human Services, makes the determination for Medicare. The Board has held that the effective date for a Medicaid-only certification is the date the State survey agency indicates that a facility has met requirements by completing a Form HCFA-1539 on line 18 and 19 (decision 107). The Board amplified this finding in decision No. 176 as follows:

> "While the date of the signature on line 19 of the C & T is presumptively the best evidence of the date a certification determination was in fact made, the Board will accept that the certification was made on an earlier date, if established by other clear evidence. This evidence must show convincingly that all the requirements for certification are met, and the survey agency not only so determines, but commits its determination in writing in the form of notification to either the single state agency or the facility."

If the facility renders service for Medicare as well as Medicaid, the Medicaid PA for SNF services will be executed retroactively to the date of the Medicare PA as required by 42 CFR 442.20(a)(2). However, the scope of 442.20 is limited to SNFs which participate in both Medicare and Medicaid programs (decision 107). The date of certification for different situations is summarized below:

Service Rendered by Facility	Earliest Effective Date Medicaid PA
1. SNF for Medicare and Medicaid	Effective date of the Medicare PA
2. SNF for Medicaid only	Date Form HCFA-1539 executed on line 18/19*
3. ICF for Medicaid	Same as item 2, above
4. SNF for Medicare and Medicaid and ICF for Medicaid	a) For SNF services for Medicare and Medicaid, the effective date of the Medicare PA b) For ICF services, date Form HCFA-1539 executed on line 18/19*
5. SNF and ICF for Medicaid only	Same as item 2, above

*or other clear evidence as set forth in decision 176.

Post July 3, 1980

New regulations, effective July 3, 1980, made the earliest effective date of a PA, for both Medicaid and Medicare, the date the onsite survey is completed, if all Federal requirements are met on that date. If all requirements are not met on the date the onsite survey is completed, the PA will be effective on the date the requirements are met or the date the provider submits an acceptable plan of correction [to the State survey

Exhibit Q, page 31.5

agency if the facility renders service to Medicaid only, or to HCFA if service is rendered for Medicare (42 CFR 442.13 and 42 CFR 489.13)].

We hope you find this memorandum useful in applying HCFA policy consistent with pertinent Board decisions. As additional Board decisions are issued in this area, we will continue to assist you in assessing their broader impact. If you have any questions about this area, please contact Gilda Martin (FTS 987-1399) or Charles V. Sessums (FTS 987-1300), Division of Financial Operations, OPA.

Lamont W. Williamson

Attachment

cc:
All Regional Administrators

BPO-P53:MARTIN:dpj:10/21/81:D20

Part 6. General Program Administration

6-193.9-00 Standards for Payment for Skilled Nursing Home Care

6-193.9-00 Answers to Questions

QUESTION 1: May a State claim Federal financial participation for payments to a skilled nursing home whose provider agreement has been terminated?

Answer: No. Federal financial participation is not available in State agency payments made to skilled nursing homes which do not have a provider agreement in effect during the period for which Federal sharing is being claimed. The Federal regulations which define "skilled nursing home" for purposes of Federal financial participation include the following as one of the essential conditions (45 CFR 249.10(b)(4)(i)(h)):

> the facility has been determined by the single State agency to meet all of the standards established under section 1902(a)(28) of the Act, as evidenced by an agreement between the single State agency and the facility for the provision of skilled nursing home care and the making of payments under the plan.

If the provider agreement which evidences the facility's compliance with the standards of section 1902(a)(28) of the Act has expired or has otherwise been terminated, the facility does not meet the definition of a skilled nursing home under title XIX, and Federal financial participation may not be claimed for payments to the facility.

When a facility appeals the termination of its provider agreement, Federal financial participation is not available for payments to the facility during the appeal, since the facility does not have a currently effective provider agreement. The fact that the facility formerly had a provider agreement gives no basis for Federal financial participation in payments to the facility for the period while

Part 6. General Program Administration

6-193.9-00 Standards for Payment for Skilled Nursing Home Care

6-193.9-00 Answers to Questions (continued)

the appeal is before the administrative agencies or the courts. If, however, State law provides for continued validity of the provider agreement pending appeal, or if the facility is upheld on appeal and State law provides for retroactive reinstatement of the agreement, the agreement would not be considered terminated during the appeal period for purposes of Federal financial participation for payments to the facility.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

6325 Security Boulevard
Baltimore MD 21207

SEP 30 1985

Mr. Conrad Thompson, Director
Bureau of Nursing Home Affairs
Mail Stop HB-11
623 8th Avenue SE
Olympia, WA 98504

Dear Mr. Thompson:

This is to bring you up-to-date on recent developments related to the implementation of the new national long-term care (LTC) survey process. We have enclosed the current draft copy of the revised survey forms as well as an information paper outlining related changes in LTC survey procedures. Revised interpretive guidelines covering both procedural details and quality assurance review areas will be available for training.

The nationwide testing of the modified long-term care survey has been completed, and we are now in the process of analyzing the data. Every State participated in the testing, which comprised more than 350 PaCS surveys. Rehabilitation Care Consultants analyzed the survey findings from the 47 non-demonstration States and submitted its evaluation report in early September. Our regional offices also monitored the implementation of the new process through the performance of comparative PaCS and traditional surveys and observational surveys. Each region has submitted a report of its findings from these surveys. In addition, the extended evaluation of the PaCS process continues to progress in Connecticut, Rhode Island and Tennessee. Brown University is conducting this more structured evaluation and has just submitted its initial findings from the three States.

In June, HCFA convened a workgroup of State surveyors to redesign the PaCS forms prior to receiving results from the two contractors. HCFA has streamlined the form according to the group's recommendations and is continuing to work with the workgroup participants to further refine it.

As you will note in examining the enclosures, we have made a number of significant changes from the process that was tested earlier this year. First, the PaCS survey instrument has been incorporated into a three-part review process which will emphasize direct resident care provision but continue to ensure that facilities comply with all current regulatory requirements. The revised process is explained in Enclosure B. We have also refined the PaCS instrument itself, which now composes the second stage of the three-part process. The most notable changes include the elimination of the tally sheet, triggering mechanism and the ADL scoring system. We have made substantial format revisions in the summary form and individual resident review section to promote surveyor ease of use. Suggested interview questions as well as the drug regimen review list

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have been removed from the survey instrument and will be inserted in the interpretive guidelines. What we have not changed, however, are the onsite surveying procedures and the substance of the resident care indicators which form the foundation of the new survey process.

We are now reviewing the findings reported by RCC, Brown University and the regional offices. Further modifications to the proposed survey forms and procedures will be based on the results of our review and on recommendations from the State surveyor workgroup. However, we anticipate that the final version of the modified national long-term care survey instrument will not differ substantially from that which we have enclosed.

A final consideration in the implementation of the PaCS process is linked to the court order in Smith v. Heckler. In this case, the court concluded that the Secretary of Health and Human Services has a duty to be informed as to whether facilities participating in the Medicaid program are providing high quality medical care. In response to the court order, the Secretary's plan of action incorporates the implementation of PaCS as the method to be used to assure high quality care in nursing homes. By October 31, HCFA will publish a Notice of Proposed Rulemaking which would require the use of a resident-oriented survey in nursing homes. We will carefully consider all comments on the proposed requirement before implementing the new survey process. You will be notified promptly of any changes this may entail in the training and implementation schedule.

We recognize that some States will need to make adjustments to current procedures in order to continue to integrate their licensure and inspection of care reviews with surveys. Planning for these changes should take place at this time to help facilitate a smooth transition.

We will continue to keep you informed on developments related to the implementation of the new LTC survey process. Thank you for your continuing cooperation in this effort.

Sincerely yours,

Sharon Harris
Sharon Harris
Acting Director
Office of Survey and Certification

Enclosures

Tab A - Revised Survey Instrument, Parts A and B
Tab B - Information Paper, PaCS Implementation Process

MARK O HATFIELD OREG CHAIRMAN

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DALE BUMPERS ARK

J KEITH KENNEDY STAFF DIRECTOR
THOMAS L VAN DER VOORT MINORITY STAFF DIRECTOR

United States Senate
COMMITTEE ON APPROPRIATIONS
WASHINGTON, D.C. 20510

10/22/85
To Jean

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Div. of Health

October 7, 1985

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OCT 25 1985
FACILITY STANDARDS
PROGRAM

Rose Bowman, Director
Department of Health and Welfare
State of Idaho
Boise, Idaho 83720-9990

Dear Rose:

Thank you for sending me a copy of your letter to Secretary Heckler.

By now, you should have received the letter I wrote to HCFA regarding your complaint. You obviously aren't going to get anything changed on the Agreement you signed in September, but I hope you have better luck next time. Please let me know if there's anything else I can do to help.

Sincerely,

Jim McClure
James A. McClure
United States Senator

McC:ms

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BUREAU OF VITAL STATISTICS STANDARDS
AND LOCAL HEALTH SERVICES

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration
6325 Security Boulevard
Baltimore, MD 21207

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Ms. Rose Bowman
Director
Department of Health and Welfare
Statehouse
Boise, Idaho 83720-9990

Dear Ms. Bowman:

Your letter to the Secretary was forwarded to the Office of Survey and Certification of the Health Standards and Quality Bureau since we are responsible for the Section 1864 Agreement, and the functions performed by the States, pursuant to the Agreement.

You raised several issues of concern in your letter: (1) that States' input in the Agreement was not reflected in the final Agreement; (2) that we dictated the terms of the Agreement and did not allow our regional offices to negotiate the terms of the Agreement with individual States; (3) that we are seeking to destroy the partnership that has existed between the State and Federal government by our assumption of absolute responsibility for the administration of the survey and certification of Medicare facilities.

These issues have been raised by a few other States and are of great significance to the survey and certification program, and the roles of the Federal and State agencies involved in implementing the program. We appreciate your concerns and I would like to address them.

In February 1984 we discussed our proposed revisions of the Section 1864 Agreement with the Association's "1864 Subcommittee". There were representatives from South Carolina, New York and Maryland at that meeting. We explained the changes; why they were made; and the legal bases for them. We accepted several comments and subsequently incorporated them into the Agreement. In late spring we again met with State Directors and West Virginia was represented at that meeting. We met finally in October 1984 with the State agency Directors from four other States: Florida, Texas, Rhode Island, and Washington. Most of the comments presented during that meeting were related to the concern that our "partnership" was not clearly conveyed by the Agreement. At that time, we stated that the Agreement is a contract; that the relationship between us is contractual. We, nevertheless, modified some of the provisions in an effort to better convey the close working relationship that we have had over the years with the States, but we could not alter the basic contractual and legal relationship. However, it was never our intent to negotiate statutory or regulatory requirements, or any other provisions that would either undermine the legal sufficiency of the Agreement, or would distort the factual roles of the State and Federal governments. The majority of the provisions in the Agreement are standard in Federal contracts, and the law and regulations require us to be as prescriptive as we are.

Our intent was to negotiate discretionary provisions and to develop a single Agreement which would be used by all States. Our goal was always to negotiate, within the limits of the statutory and regulatory requirements, a single Agreement for all of the States. This is critically important if we are to ensure a uniform and consistent survey and certification program nationwide. We informed our regional offices that to ensure uniformity we would respond to all States concerns in a letter to the States. We have been collecting State comments and plan to issue a letter with clarifying statements concerning provisions in the Agreement, within the next month.

The Federal Government, through the Department of Health and Human Services and the Health Care Financing Administration (HCFA) is the sole administrator of the Medicare program. None of the statutory authorities or responsibilities have been delegated below the Federal level. This means that the States are not permitted to establish or interpret participation requirements. The States cannot establish Medicare policy, nor despite their expertise, may they encroach upon the prerogatives that are exclusively HCFA's. Over the years, the Federal and State governments have worked together in a cooperative effort to ensure health and safety of Medicare beneficiaries. The contractual relationship that exists between us, however, does not preclude the exchange of ideas and meaningful participation in the decision-making process.

We remain interested in your concerns and recommendations for improving the program. When the Agreement is again revised, we will again make every effort to negotiate those provisions that are legally negotiable.

Sincerely yours,

Sharon Harris
Sharon Harris
Acting Director
Office of Survey and Certification

Chron file

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

October 29, 1985

Mr. C. McClain Haddow
Acting Administrator
Health Care Financing Administration
Department of Health and Human Services
Room 700, East High Rise Building
6325 Security Boulevard
Baltimore, Maryland 21207

Dear Mr. Haddow:

At the request of the Chairman, Senate Special Committee on Aging, the General Accounting Office is reviewing the standards enforcement program for skilled nursing and intermediate care facilities. A major objective of our review is to determine why facilities which chronically fail to meet certain requirements in the federal standards have been allowed to continue in the Medicaid program. In this regard, we analyzed requirements in current federal regulations dealing with survey and certification and those additional guidelines to state survey agencies set out in the State Operations Manual. We currently are conducting field work both to evaluate the effectiveness of those regulations and guidelines and to determine the extent to which the Health Care Financing Administration (HCFA) and the state survey agencies follow them. Our work to date at both HCFA and the state level has revealed a lack of uniformity in interpreting the meaning and applicability of some of the regulations and guidelines. Therefore, we are requesting an official HCFA interpretation to resolve those variances. We have also included several questions dealing with issues where, to our knowledge, HCFA has not formulated guidelines. Our questions are included in Attachment I.

We are relying heavily on the Medicare-Medicaid Automated Certification System (MMACS) to identify those facilities which repeatedly fail to meet specific requirements in the standards. Because of the numerous requirements, we are attempting to identify those which are considered to be the most important with regard to assuring patient health, safety and quality care. We have developed an abbreviated list of requirements which was based, at least in part, on prior HCFA efforts to identify "critical" or "class B" requirements and those requirements highlighted in the Patient Care and Services project. We are now attempting to determine whether there is a consensus on those requirements by participants in the program, including nursing home operators, patient advocacy organizations and various professional groups. A copy of our questionnaire and a list of parties queried is included for your information as Attachment II. Should your agency have any questions or observations regarding the questionnaire, please feel free to notify us.

Because of our rather tight timeframes, we would appreciate receiving your reply to the questions in Attachment I within 30 days. You may mail your response, to my attention, to the following address:

U.S. General Accounting Office
Room 1126, Switzer Building
330 C Street, S.W.
Washington, D. C. 20201

If you have any questions about this request, please call me at FTS 426-5246, or Mr. James Hoffman of our Kansas City Regional Office at FTS 757-3729.

Sincerely yours,

Kathryn G. Allen

for James R. Linz
Group Director

Attachments - 2

cc: Ron Miller, Executive Secretariat

REQUEST FOR CLARIFICATION OF FEDERAL REGULATIONS AND GUIDELINES

As part of our review, we researched the history of proposed and implemented survey and certification regulations and other guidelines for skilled nursing facilities (SNF) and intermediate care facilities (ICF). Because of our emphasis on chronic non-compliance with specific requirements, we noted with special interest that, as early as 1970, the importance of dealing with repeat deficiencies was recognized in Medicaid regulations. As you know, repeat deficiencies were also recognized in the 1974 final rules for both Medicare and Medicaid. Those regulations, which remain basically unchanged to the present, provide special rules for dealing with repeat deficiencies.

While many of our questions refer to those regulations and guidelines dealing with repeat deficiencies, several relate to their applicability to ICFs as well as SNFs. In our analysis of the Medicaid regulations and the instructions and examples in the State Operations Manual, we noted that some of the language appears to be more relevant to the SNF program, which has a clear, universally understood requirements structure consisting of conditions of participation, standards and elements or factors. However, the ICF program does not have this clear structure and we occasionally had difficulty in applying provisions and instructions in the regulations and guidelines to that program.

We have also included several questions covering unresolved issues identified to date in our field work. These issues are not addressed in the current regulations or in the State Operations Manual.

In the following questions, we make reference to the "old" and "new" State Operations Manual. The "old" manual is the April 1980 edition, as revised. The "new" manual is the March 1985 edition.

In responding to the following questions, please include

--a clear indication where your response is different for SNF and ICF, and

--any formal interpretations or guidelines other than the State Operations Manual which the agency has issued in the last 5 years dealing with matters covered in our questions.

I. REGULATION INTERPRETATIONS

A. Medicaid regulations (42 CFR 442.105) specify that a state survey agency can recertify a facility which is deficient in meeting standards if the following conditions exist.

--The deficiencies, individually or in combination, do not jeopardize the patient's health or safety nor seriously limit the facility's capacity to give adequate care (442.105(a)).

--The facility has an acceptable written plan for correcting the deficiencies (442.105(b)).

--If the facility was previously certified with a deficiency and has a different deficiency at the next survey, the facility:

- Was unable to stay in compliance with the standard for reasons beyond its control and/ or despite intensive efforts to comply, and
- Is making the best use of its resources to furnish adequate care (442.105(c)).

--If the facility has the same deficiency it had under the prior certification, the facility

- Did achieve compliance with the standard at some time during the prior certification period,
- Made a good faith effort to stay in compliance and
- Again became out of compliance for reasons beyond its control (442.105(d)).

In the above regulations,

1. What is meant by a "deficiency"?
   a. Any of the requirements (i.e., data TAG) listed on the Survey Report Form reported as "not met"?
   b. A specific undesirable condition? (please use example)
2. What is meant by the term "different deficiency" in 442.105(c)? (please use example)
3. What is meant by the term "same deficiency" in 442.105(d)? (please use example)

B. We have found some variances of opinion as to what constitutes a "standard" in the ICF program. Some interviewees expressed the opinion that every requirement (i.e., data TAG) shown on the Survey Report Form (HCFA 3070) is a standard. However, other interviewees told us that some of the requirements listed on the HCFA 3070 are considered as elements rather than standards.

1. Are all requirements listed on the HCFA 3070 classified as standards?

2. If "no",

   a. Which of the requirements are classified as standards? (please cite TAG numbers).

   b. What is the classification of each of the remaining requirements listed on the HCFA 3070? (please cite TAG numbers).

C. Both 442.105(c)(1) and 442.105(d)(1) refer to "compliance with the standard".

1. Does this literally mean that the deficiencies must result in a standard being reported as not met in order for these regulations to apply?

2. If "yes", does this mean that the regulations would not apply when a facility repeatedly fails to meet a certain "element" or "factor" but the related standard is shown as "met"?

D. According to regulation 442.105, at the end of each survey, the survey agency must evaluate all deficiencies found and render a judgment as to whether the deficiencies are so serious that the facility must be decertified (442.105(a)). In taking this "vertical" view, the survey agency considers whether the currently identified undesirable conditions pose a threat to patient health or safety or seriously limit the facility's capability to provide adequate care. Assuming that the survey agency concludes that the facility passes the "vertical" test, the facility is then subjected to a "longitudinal", or historical, test in which patterns of non-compliance are analyzed (i.e. 442.105(c)and(d)).

As we interpret the regulation, it is vital that the survey agency be able to demonstrate threats to health or safety or severely diminished capacity to provide care in order to decertify a facility under the "vertical" test. However, as we also interpret the regulation, under the "longitudinal" test, the survey agency is not required to demonstrate that health, safety or capacity to provide care is a critical issue but merely that the facility has a historical pattern of undesirable behavior, as evidenced by the repeat deficiencies.

1. Are our interpretations of the regulation correct? Specifically, do the regulations permit decertification for repeat deficiencies where those deficiencies may not clearly present a threat to patient health or safety or diminished capacity to provide care? (Please elaborate).

2. Can you cite any appeals cases at the federal or state level where a decertification action based on historical noncompliance was overturned because of failure to demonstrate that the current conditions in the facility posed a threat to health or safety or capacity to provide adequate care?

3. When a SNF has serious compliance problems at the standards and element level but the related conditions of participation are reported as being met, can the survey agency proceed with termination under the provisions of 442.105(a)? That is, can a SNF be terminated when conditions of participation are reported to be met?

E. Medicare regulations (42 CFR 405.1907(a) and 1908(b), (e)) contain language very similar to the Medicaid regulation (422.105) with regard to subjecting the facility to both "vertical" and historical tests and in dealing with repeat failures in meeting the same standard.

1. Because of this similarity, would your answers to questions C and D above be the same if applied to the Medicare regulations? (If "no", please elaborate).

2. Is there any significance to the fact that the Medicare regulation does not refer to the term "deficiency"?

F. Medicare regulations (405.1908(d)) also include a requirement that, when a facility fails to meet different standards in a succeeding survey, certain determinations must be made.

1. What is the intent of this requirement?

2. Does this provision apply only when the standards are within the same condition of participation?

3. The Medicaid regulations do not include a comparable requirement. Is there a reason for this variance?

II. ACCEPTABLE PERIOD FOR CORRECTION

A. Medicaid regulations (442.105(e), 442.111(a), 442.112) indicate that, with certain exceptions for facility-related deficiencies in ICF, all deficiencies must be corrected within 12 months. Assuming a facility with deficiencies receives a "conditional" certification (442.111(c)), the facility could have a full 12 months to complete corrective action, assuming the survey agency considers such a timetable to be acceptable. However, assuming that the facility receives a "short term" certification (442.111(b)) of 6 months, it is our interpretation that the proposed corrective actions must be completed within that 6 month period. This interpretation is based on the fact that 442.105 prohibits the recertification of facilities with open deficiencies from the prior certification period, with the exception of those circumstances set out in (c) and (d) of that regulation.

   1. We interpret the regulations as allowing the provider the lesser of the length of the certification period or 12 months to complete corrective action. Is this interpretation correct? (If "no", please elaborate.)

B. The State Operations Manual provides that, when a "conditional" certification is used, the survey agency is to conduct a follow-up prior to the automatic cancellation date to determine whether all deficiencies have been corrected. The manual further provides (old: section 3306; new: section 2732) that, if some deficiencies have not been fully corrected but the provider is making "substantial progress" in correcting them, the survey agency can elect to waive the cancellation clause. In this situation, the survey agency is to require the provider to submit an amended plan of correction showing the revised dates for completing corrections.

   1. Where the above situation occurs, must all revised correction dates be within the current certification period? (If "no", please elaborate.)

C. The State Operations Manual (old: section 3300; new: section 2734), in discussing the concept of "compliance with correctible deficiencies", conveys the impression that a facility can be recertified even though it continues to have the same uncorrected deficiencies, depending on the nature and seriousness of the deficiencies and with the effort entailed in achieving correction.

1. Does the concept of "compliance with correctible deficiencies" presented in the State Operations Manual provide for additional exceptions? That is, does the state survey agency have discretion to allow corrective actions to extend into another certification period for reasons other than those discussed in A and B above?

D. Medicare regulations (42 CFR 405.1907(b)) specify that, in most circumstances, 60 days should be ample time for providers to take corrective action. We interpret this language as guidance to both the survey agency and the providers as to what is a "reasonable" period of time to correct most deficiencies. The Medicaid regulations do not include a similar provision.

1. Is the 60 day "rule of thumb" equally applicable to the Medicaid program?

2. If "yes", should this provision be added to the Medicaid regulations?

III. TYPE OF CERTIFICATION

A. Medicaid regulations (42 CFR 442.111) require that one of two types of certification be used when facilities have deficiencies:

--a "conditional" 12 month certification with an automatic cancellation date tied to correction dates shown in the provider's plan of correction (442.111(b))

--a "short-term" certification of less than 12 months, which is tied to correction dates shown in the provider's plan of correction (442.111(c)).

The State Operations Manual (old: sections 2440, 3156; new: section 2736) recommends that the "conditional" certification be used when the provider, by its past performance in correcting deficiencies, can reasonably be expected to make the necessary corrections. The guidelines further provide that the cancellation clause must be invoked if follow-up indicates that the corrections were not completed or if the provider is not making "substantial progress" in carrying out the plan of correction.

The old State Operations Manual (section 3156) recommended that the "short term" certification be used where a provider's history has been marked with protracted delays in correcting deficiencies. The guideline further provided that, if all required corrections to achieve compliance with the standard were not completed by the end of the certification period, the certification should not be renewed. The new State Operations Manual (section 2736) recommends that the "short term" certification be used when a SNF has deficiencies in one or more standards.

With regard to the above regulations and guidelines,

1. When "short-term" certifications are used and adequate corrective action has not been taken by the end of the certification period, can the certification be renewed if the provisions in 442.105 (c), (d) are met?

2. Regardless of type of certification, when full resurveys are conducted before the end of the current certification period and repeat deficiencies are identified, should recertification decisions be delayed until the end of the certification period so that:

   --the provider has full opportunity to achieve compliance, and

   --if compliance is not achieved, the survey agency can then make the determinations specified by 442.105(c),(d)?

3. Should survey agencies always use the "short term" certification for facilities with repeat deficiencies?

B. Medicaid regulations (442.111) require that the automatic cancellation dates on "conditional" certifications and the ending date for "short term" certifications must be no later than 60 days after the last day specified in the plan for correction of deficiencies.

   1. What is the intent of this requirement?

2. What are the potential negative effects if survey agencies establish dates which are considerably past the 60 day limit (e.g. 90 to 120 days)?

C. Medicaid regulations (442.16) permit the state Medicaid agency to extend the provider agreement for up to 2 months beyond the current agreement expiration date. In order to do so, the survey agency must first provide written notice that the extension will not jeopardize patient health or safety and such extension is needed to prevent irreparable harm to the facility or hardship to patients or the survey agency needs more time to make a certification decision.

1. Does HCFA allow any subsequent, follow-on extensions of the provider agreement where the original 2 months extension does not provide adequate time to resolve the issues (e.g., relocation, certification decision, due process)?

2. If "yes",

    a. Are there any time limits?
    b. Is HCFA approval required?
    c. If HCFA approval is required, who is authorized to grant such approval?

IV. OTHER MATTERS

A. The May 27, 1982 proposal (47 FR 23404) to revise the Medicare and Medicaid survey and certification regulations would have eliminated current provisions covering repeat deficiencies and the time limited certifications (i.e., "short term", "conditional").

1. Why did HCFA conclude that these provisions should be dropped?

B. We have heard from various sources that, when the Patient Care and Services (PACS) tool is adopted, the current SNF and ICF Survey Report Forms (HCFA 1569 and HCFA 3070) will be eliminated.

1. Is this, in fact, planned?

C. Many states reportedly now have state licensing standards with requirements which are at least equal to those requirements in the federal standards. Assume that in such a state the following situation occurs.

--The survey of a facility discloses that there are repeat deficiencies from the prior survey in various federal and the related state requirements.

--Despite the repeat deficiencies in the state requirements, the survey agency elects to renew the state license.

In the above situation

1. Would HCFA expect the survey agency to withdraw or not renew Medicaid certification, assuming that criteria set out in 442.105(c),(d) was not met?

2. Would it be difficult to sustain such a termination action on appeal, given that the provider could demonstrate that the state license, which is based on meeting comparable requirements, was renewed?

D. Medicaid survey and certification regulations (42 CFR 442) are not totally clear on what constitutes a "provider". For example, regulation 442.14 indicates the "provider" is the facility owner. Medicaid financial disclosure regulations (455, subpart B) requires the "provider" to disclose ownership and control information. As you know, this disclosure information is shown on the HCFA Form 1513. Among the disclosure categories on that form is "ownership interest", which includes secured creditors. We noted that provider agreements are generally issued to the "name of entity" shown in section I of that form. We also noted that, in most instances, the survey agency transmitted the statement of deficiencies (HCFA 2567) to the facility administrator and that, in most cases, the day-to-day interaction in resolving deficiencies was also with the administrator, who often is not an owner.

1. Which parties listed on the HCFA 1513 does HCFA consider to be the Medicaid "providers" and Medicare "providers" (if different)?

    a. Are secured creditors considered to be "providers"?

2. Medicare regulations (42 CFR 489.18) specify that, when a facility is leased, the lessee is the "provider". Is this also the case in the Medicaid program?

3. In the event of a termination action, which parties on the HCFA Form 1513 must be notified to meet due process regulations (42 CFR 431, subpart D)?

4. In the interests of due process, should survey agencies immediately notify all "providers" whenever survey results indicate that a termination action may be forthcoming?

E. Medicaid regulations (442.14) provide that, when a change of ownership occurs during a provider agreement period, the Medicaid agency must automatically assign the agreement to the new owner. The regulation also requires the new owner to carry out any previously agreed-to plans of correction. However, we found no guidance in either the regulations or the State Operations Manual as to how survey agencies should proceed in those instances where termination action has either been initiated or is imminent and the provider (owner or lessee) elects to sell or lease-out the facility.

1. Does HCFA expect the state survey agency to defer termination to allow a new owner or operator a "reasonable" period of time to demonstrate the capability for, and commitment to, correcting deficiencies?

2. If "yes",

   a. Is the survey agency expected to verify and evaluate the terms of the transaction to assure there is an "arms length" change in owner or operator?

   b. Should the time allowed be covered by a

      --2 month extension in the provider agreement as recommended by the survey agency (442.16)?

      --a "short term" certification (442.111(b))?

      --other? (please elaborate)

3. Can you cite any cases where a survey agency declined to suspend an ongoing termination action upon change of ownership or lessee and the termination was subsequently overturned because the new owner or lessee was not given an opportunity to correct the deficiencies?

4. If an ongoing termination action is based primarily on historical non-compliance rather than on immediate threat to patient health or safety or inability to provide adequate care (see question I. D. 1.), would change of owner or lessee nullify the case?

5. In evaluating the historical compliance record of a facility to determine appropriateness of an adverse action, must this evaluation be limited to the record of the current owner or lessee?

F. We have noted instances where a termination action was pending or underway and the provider attempted to resolve the problem by proposing to replace one or more key personnel, such as the administrator or nursing supervisor(s). In several of these instances, the provider maintained that the "reasons beyond its control" provisions of 442.105(c),(d) were applicable because key staff had full responsibility for day-to-day operations, including assuring compliance with standards. In many of those cases, "absentee ownership" was involved--i.e., the owner lived out-of-state or the facility was chain-operated. One absentee owner maintained that he was totally unaware that the facility had compliance problems until he was served with a formal termination notice. We also noted two instances in which owners contracted with a "management company" to operate their facilities and proposed to retain a new company after being served with a termination notice.

1. In those instances where providers propose to change key employees, does the "opportunity to correct" concept require that the survey agency delay or suspend termination action to provide the new personnel time to demonstrate whether they can bring the facility into compliance?

2. Can you cite any cases where a survey agency lost a termination case on appeal because it refused to allow new key personnel time to resolve compliance problems?

3. The regulations (442.105(c),(d)) permit recertification of facilities with repeat deficiencies under certain circumstances. One key consideration is whether the recurring non-compliance was due to reasons beyond the facility's control. In HCFA's opinion, does "reasons beyond its control" include these situations where providers have

a. Vested full responsibility for facility operation in key employees, such as the administrator?

b. Contracted with a "management company" to operate the facility?

G. On August 14, 1981, the Health Standards and Quality Bureau issued a memorandum to the HCFA regional offices emphasizing that providers have the right to disagree with findings of the state survey agency. The document indicated that this was merely a clarification of existing policy. The State Operations Manual (old: 3302; new: 2728) recognizes that a provider may disagree as to whether a deficiency exists. However, no guidance is provided on how to resolve this disagreement.

1. What is HCFA's policy with regard to resolving disagreements as to whether a certain deficiency exists and/or whether a reported condition results in a requirement being "not met"?

REQUIREMENTS QUESTIONNAIRE

Attached, for your information, are the following documents:

--a sample cover letter explaining our effort to identify federal nursing home requirements which are considered to have the greatest impact on patient care, health and safety,

--the questionnaire transmitted to various organizations and groups to obtain this information, and

--a list of organizations and groups receiving the questionnaire.

[COMMITTEE STAFF NOTE: On October 31, 1985 the Health Care Financing Administration published a proposed rule governing the Long Term Care Survey process in response to a Federal court order in the case Smith v. Heckler. See Federal Register pages 45584 through 45587.]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date NOV 12 1985

From Richard P. Kusserow
Inspector General

Subject OIG Draft Audit Report - Implementation of the Alternative to Nursing Home Decertification Provisions of the Omnibus Reconciliation Act of 1980 - ACN: 03-60155

To C. McClain Haddow
Acting Administrator, Health Care
Financing Administration

Attached for your review and comment is a draft audit report on the results of our review of the implementation of the alternative to nursing home decertification provisions of the Omnibus Reconciliation Act of 1980. These provisions allow the Secretary to deny reimbursement to substandard nursing homes for new admissions in lieu of the more drastic sanction of terminating such homes' participation in Medicare or Medicaid.

To implement the Act, HCFA issued proposed regulations in early 1985. In our opinion, the proposed rules generally are in accord with the legislation and the intent of Congress. However, HCFA should consider our recommendations that the regulations and instructions:

- o More clearly specify those conditions under which sanctions would be imposed.
- o Provide specific timeframes for each step within the sanction process to ensure either timely correction of deficiencies or imposition of the sanctions.

Once this is accomplished, HCFA should move quickly to identify chronically-substandard nursing homes and apply the new fiscal sanction as an incentive for improving conditions under which Medicare and Medicaid patients must live. In this regard, my office has identified 44 such homes that are likely candidates for sanctions and require HCFA's immediate attention. We will be pleased to assist HCFA in further identification efforts.

If you or your staff wish to discuss the material contained in this draft report, please let me know or contact F.J. Majka, Assistant Inspector General for Audit. We would appreciate receiving your comments within 30 days from the date of this memorandum.

Attachment

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REVIEW OF THE IMPLEMENTATION OF THE ALTERNATIVE TO NURSING HOME DECERTIFICATION PROVISIONS OF THE OMNIBUS RECONCILIATION ACT OF 1980

DEPARTMENT OF HEALTH & HUMAN SERVICES USA

NOTICE

"This draft of a proposed Office of Audit report is being made available for review and comment by officials having management responsibilities concerning the matters presented. This draft report is not to be considered final as it is subject to further review and revision. Please adequately safeguard this document against unauthorized use."

OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDIT

Audit Control Number 03-60155

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Appendix A - Survey Criteria Used To Identify Long Term Care Facilities for Further Review

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EXECUTIVE SUMMARY

This report summarizes the results of our review of the implementation of the alternative to nursing home decertification provisions of the Omnibus Reconciliation Act of 1980. These provisions give the Secretary authority to impose on a nursing home an intermediate sanction -- denial of reimbursement for new admissions -- in lieu of the more drastic step of terminating the facility's participation in Medicare and Medicaid.

We made our review at the request of the Chairman of the United States Senate Special Committee on Aging. The objective of our review was to determine what the Health Care Financing Administration (HCFA) needs to do to ensure effective implementation of the Act.

We believe that HCFA will shortly be in a position to finalize the proposed regulations. A Notice of Proposed Rule Making (NPRM) was issued and public comments thereon are being evaluated. The proposed regulations, when finalized, could be an effective force for improving conditions under which thousands of Medicare and Medicaid patients in nursing homes must live. However, HCFA must aggressively enforce the regulations and apply the intermediate sanction if these improvements are to be achieved.

We are recommending that HCFA finalize the regulations after giving consideration to our recommendations that the regulations and instructions

... clearly specify conditions under which sanctions will be imposed, and

... provide for specific timeframes for each step within the sanction process.

We are also recommending that, to achieve the greatest results in the shortest time, HCFA initiate a special nationwide review to identify chronically-substandard nursing homes and apply the intermediate fiscal sanction as an incentive to facilities for improving conditions.

In this connection, we identified 44 skilled nursing facilities (SNFs) that display strong indications of chronic substandard conditions. These 44 SNFs--the names of which will be furnished under separate cover--are likely candidates for the intermediate sanction and require HCFA's immediate attention. We offer our assistance in identifying intermediate care facilities (ICFs) and intermediate care facilities for the mentally retarded with indications of continuing noncompliance with important conditions of participation.

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RESULTS OF REVIEW

Omnibus Reconciliation Act of 1980 Provides an Alternative to Nursing Home Decertification

Nursing facilities participate in the Medicare and Medicaid programs under agreements with HCFA and State Medicaid Agencies. To qualify for a provider agreement, facilities must first be certified by a State survey agency as complying with certain minimum health and safety requirements. The requirements, also referred to as conditions of participation, or standards, are set forth in sections 1861(J) and 1905(C)(D) of the Social Security Act. Nursing facilities are surveyed periodically by State survey agencies to determine their compliance with the requirements.

Before the enactment of the Omnibus Reconciliation Act of 1980 (Public Law 96-499), if a State survey agency determined that a facility no longer substantially met the conditions of participation or standards under Medicare or Medicaid, the only Federal sanction available was to terminate the facility's provider agreement. This action, in effect, terminated a facility's participation in both the Medicare and Medicaid programs.

Congress was concerned that many substandard facilities were allowed to continue in the programs because termination was oftentimes neither feasible nor desirable in view of nursing bed shortages and the possible trauma that relocation often causes the elderly. Congress, therefore, legislated an intermediate fiscal sanction (denying reimbursement for new admissions for a period of up to 11 months) to encourage substandard nursing homes to quickly correct noted deficiencies. In doing so, Congress intended to ensure the uninterrupted stay of the homes' patients while protecting them from potentially harmful health effects arising from prolonged exposure to substandard conditions.

This new sanction did not in any way lessen the Secretary's authority and responsibility to terminate facilities when conditions represent "immediate jeopardy" to patients. In these cases, the Secretary is to begin termination procedures immediately and halt further reimbursements for new admissions.

Some Modifications Needed in Proposed Sanctions

In June 1984, the Chairman of the United States Senate Special Committee on Aging submitted several requests for audit to the Office of Inspector General. One request was to determine the progress the Secretary had made in implementing the alternative to decertification provisions of the

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Omnibus Reconciliation Act of 1980. The Chairman expressed concern that HHS' failure to implement the provisions allowed chronically-substandard nursing homes to continue program participation to the detriment of Medicare and Medicaid patients and American taxpayers. The Chairman cited one example of a chronically-substandard nursing home and questioned how widespread the problem might be.

An NPRM was issued on February 21, 1985, and public comments are being reviewed. HCFA officials anticipate issuing final regulations sometime in calendar year 1985.

As part of our audit, we reviewed the requirements in the NPRM and find that generally they are in accord with the legislation and the intent of Congress. We believe, however, that some further guidance in the final rules as well as in instructions are needed regarding the specific conditions under which sanctions are to be imposed. In addition, we suggest that timeframes for completing the sanction process be specified.

Conditions Under Which Sanctions Should be Imposed

The legislation permits the intermediate sanction to be imposed (1) in conjunction with termination procedures when deficiencies pose "immediate jeopardy" to the health and safety of nursing home patients and (2) in lieu of termination procedures when there is no "immediate jeopardy" to the patients. According to the legislative history accompanying the Act, Congress intended the Secretary to define by regulation the grounds for the imposition of an intermediate sanction. Congress expected that the existence of sanctionable deficiencies with the conditions of participation would generally be determined during the course of the formal State survey.

We believe that the proposed definitions for imposing the sanctions -- both termination and the intermediate sanction-- are too general, allow too much flexibility, and must be clarified to ensure uniformity of application. For example, a nursing facility must be terminated if its deficiencies pose "immediate jeopardy" to patients' health and safety. This is defined as any situation in which a facility's non-compliance with one or more conditions of participation pose a serious threat to patients' health and safety such that immediate corrective action is necessary. Two examples are cited in the proposed rule. Other than the examples, the determination of what poses a serious threat to patients' health and safety is left to the subjective judgment of pertinent authorities.

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The same is true in cases where "immediate jeopardy" is not an issue. The NPRM states that an intermediate sanction can be applied if the facility no longer meets one or more of the conditions or standards. Again the determination is left to the judgment of pertinent authorities.

To lessen the impact of subjective judgment on the imposition of sanctions -- this is necessary in view of the critical issue of "immediate jeopardy" and the fact that hundreds of nursing facilities fail one or more conditions or standards and are thus subject to the intermediate sanction if not termination -- HCFA should provide further clarification in the preamble of the final rule, including using more examples. In addition, HCFA should provide in instructions further guidance to ensure that there are standard methods for identifying nursing facilities that warrant imposition of a sanction. We recommend that this method be tied in to specific conditions or standards nursing homes failed as noted by the State survey since the survey process itself is basically standardized.

Our final concern regarding uniformity of applying the sanctions relates to a differentiation between Medicare and Medicaid in cases where "immediate jeopardy" exists. The proposed regulations require the Secretary to impose the intermediate sanction whenever the termination process is initiated against a Medicare provider. State Medicaid Agencies are given an option as to whether or not the intermediate sanction should be imposed against Medicaid-only facilities.

We realize that this discretion is provided for in existing legislation. However, since there are about 3,300 nursing homes that participate in Medicaid only, it seems only fair and equitable that these facilities operate under the same ground rules as facilities that participate in Medicare. More importantly, mandated denial of payment to Medicaid facilities could directly benefit Medicaid patients as the facilities would have a strong incentive to correct deficiencies quickly. Appropriate legislative change should therefore be sought.

Timeframes for Completing the Sanction Process

HCFA is considering changing the effective date of termination from 15 days to 2 days for facilities shown to be subjecting patients to "immediate jeopardy." We would strongly support such a change. However, we recommend that consideration be given to making 2 days the maximum effective date since there may be cases where less than 2 days is warranted.

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We also believe that restrictive timeframes need to be established for other milestones within the sanction process. For instance, before denying payments for new admissions, the facility must be given a notice of the deficiencies and an opportunity to correct them. If the deficiencies are not corrected, the facility will be given an opportunity for a hearing prior to denial of payments. After the decision to deny payments is made following the hearing, the facility and the public must be notified before the effective date of the denial.

The NPRM does not provide adequate maximum timeframes for completing this process. Of particular concern is the fact that prior to denying payment for new admissions, HCFA or the State Agency "would provide a facility the opportunity to correct its deficiencies through an approved plan of correction." Again, no specific timeframes have been stated to complete this important step.

We recommend that there be specific timeframes for each step within this sanction process to ensure either timely correction of deficiencies or imposition of the sanctions.

Sanctions Must be Aggressively Enforced

The ability to impose intermediate sanctions will certainly represent a positive step toward improving nursing home conditions. The sanction's deterrent effect can have a significant impact; however, aggressive enforcement will be necessary. The need for such enforcement is evidenced by the fact that HCFA's Medicare/Medicaid Automated Certification System (MMACS) shows that the incidence of substandard nursing facilities is widespread.

MMACS is designed to display the results of annual inspections made by State survey agencies. It shows the current status of all nursing homes in meeting the conditions of participation as contained in Federal regulations. SNFs, for example, are measured on 18 conditions of participation and over 500 standards and elements within these 18 conditions.

To determine the extent that substandard nursing facilities participate in Medicare and Medicaid, we decided to use MMACS and to initially concentrate on all SNFs or SNF/ICF combinations. Keeping in mind that the proposed regulations allow for the imposition of the intermediate sanction if only one condition or standard is failed, we selected 7 of

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the 18 conditions and 25 of the over 500 standards/elements (Appendix A) we felt were most related to patient care. We designed computer programs to identify facilities that failed:

...a selected condition of participation for two or more consecutive years,

...three or more selected conditions of participation in any of the last three most recent surveys,

...any one of the selected conditions of participation two or more times,

...any one of the selected standards three or more consecutive times.

There were 972 nursing facilities that failed one or more of our parameters. We selected a number of these providers in various States to verify the data on MMACS. Our review showed that the facilities identified were in fact problem providers who over the course of the past several years showed patterns of noncompliance with important conditions of participation. Our review also showed, in our opinion, a need for an intermediate sanction to encourage timely correction of deficiencies.

This situation is not restricted to SNFs. We performed a similar review for 2,681 ICF/MRs listed on MMACS in April 1985 and found that 2,153 of them had failed at least one standard or element. More importantly, 946 ICF/MRs (35 percent of the universe) failed one or more of the 29 standards/elements identified by HCFA as being critical to the provision of quality care. Some of the more noticeable failures according to MMACS were as follows:

> Active Treatment - 95 facilities were out of compliance with the requirement for providing active treatment to residents. This requirement was a stipulation by Congress to ensure that the mentally retarded receive the services they need. Sixty-seven of the 95 ICF/MRs out of compliance with this element are located in Connecticut and Texas. Kansas accounted for another seven.

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Qualified Mental Retardation Professional - 176 facilities failed this standard which required 9 different disciplines that are involved in supervising a plan of care for ICF/MR residents. At least one of these professional disciplines was lacking in each of the facilities which failed. New York, Connecticut and Louisiana accounted for 73 of the 176 facilities.

Physical/Mechanical Restraints - 38 facilities applied physical restraints to patients without just cause or applied mechanical restraint devices which could cause physical injury or discomfort. Connecticut had 11 of these facilities; Louisiana and Ohio had 4 each.

Chemical Restraints - 27 facilities used drugs excessively, as punishment, for the convenience of the staff or as a substitute for active treatment. Mississippi led the nation with 11 of these facilities while Georgia and Connecticut had 3 each.

Fire Protection - 96 facilities were out of compliance with the Life Safety Code of the National Fire Protection Association. New York had 45 of these facilities, Connecticut had 10, and Louisiana had 8.

We recognize, of course, that it is not feasible to immediately begin the process of applying the intermediate sanction on all 972 SNFs and 946 ICF/MRs which we identified from MMACS. Some obviously are much worse than others. The point is: HCFA can use MMACS to identify nursing facilities with the most aberrant patterns of care. A nationwide initiative could then be started to concentrate enforcement efforts against such facilities.

In this regard, we identified 44 SNFs from MMACS that failed one or more of seven selected conditions of participation in the two most recent surveys. The following chart shows the extent of deficiencies at these nursing homes and that, on the average, the deficiencies have grown in number from the previous survey to the most current.

	Averages		
	Total Deficiencies	Failed Conditions	Failed Critical Elements*
Current Survey	52	2.64	5.02
Previous Survey	48	2.21	4.74

* HCFA identified all conditions and certain standards and elements as being "critical" in evaluating the quality of care provided by nursing facilities.

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Examples of the types of information available from MMACS showing the nature of the deficiencies at four of these facilities follows:

Facility A

This 976-bed city-government owned facility failed 10 conditions of participation in the most recent survey, including three of our selected conditions of participation (Dietetic Services, Infection Control, Nursing Services). The facility also failed the same three selected conditions of participation in the prior survey. The facility had a total of 142 deficiencies of which 14 were critical. MMACS indicated no current adverse action against this provider.

Facility B

This 126-bed proprietary facility failed six conditions of participation in the most recent survey, including one of our selected conditions of participation (Nursing Services). The facility also failed this selected condition of participation in the prior survey. The facility had a total of 54 deficiencies of which 2 were critical. MMACS indicated no current adverse action against this provider.

Facility C

This 109-bed proprietary facility failed three conditions of participation in the most recent survey, including one of our selected conditions of participation (Nursing Services). The facility also failed this selected condition in the prior survey. The facility had a total of 54 deficiencies of which 7 were critical. MMACS indicated no current adverse action against this provider.

Facility D

This 323-bed county-government owned facility failed seven conditions of participation in the most recent survey, including one of our selected conditions of participation (Nursing Services). The facility also failed this condition of participation in the prior survey. The facility had a total of 135 deficiencies of which 11 were critical. MMACS indicated no current adverse action against this provider.

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Conclusions and Recommendations

HCFA is moving towards finalizing regulations for imposing the intermediate sanction authorized by the Omnibus Reconciliation Act of 1980. We believe that some modifications and further clarifications are needed to strengthen these sanctions and to ensure uniform application among nursing facilities under Medicare and Medicaid.

Once this is accomplished, HCFA should move swiftly to take advantage of the incentive offered by the intermediate sanction. The quicker the sanction is applied and the frequency of application will, in our opinion, determine the success of the effort to improve conditions under which Medicare and Medicaid patients in nursing homes must live.

HCFA, in this case, can act quickly. It should begin the intermediate sanction process with the 44 SNFs we have identified from MMACS and should expand its efforts to ICFs and ICF/MRs which can also be similarly identified. The Office of Inspector General will furnish the names of the 44 SNFs under separate cover, and will assist in the additional identification effort if requested to do so.

We therefore recommend that HCFA:

(1) Issue final regulations and instructions implementing the alternative to decertification provisions authorized by the Omnibus Reconciliation Act of 1980 as soon as possible, giving consideration to the changes recommended in this report.

(2) Review the current circumstances for each of the facilities we identified from MMACS to determine the appropriateness of applying the intermediate sanction to these facilities.

(3) Use MMACS to identify other nursing facilities requiring similar review.

(4) Seek legislative change to provide that Medicaid-only nursing facilities be required to operate under the same ground rules as facilities that participate in Medicare/Medicaid.

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Appendix A

Survey Criteria Used To Identify Long-Term Care Facilities For Further Review

Selected Conditions of Participation

Medical Direction
Physician Services
Nursing Services
Dietetic Services
Pharmaceutical Services
Physical Environment (includes Life Safety Code)
Infection Control

Selected Standards

Physician Services

Patient supervision by physician
Availability of physicians for emergency patient care

Nursing Services

Director of nursing services
Charge nurse
24 hour nursing service
Patient care plan
Rehabilitative nursing care
Supervision of patient nutrition
Administration of drugs
Conformance with physicians drug orders
Storage of drugs and biologicals

Dietetic Services

Staffing
Menus and nutritional adequacy
Therapeutic diets
Frequency of meals
Preparation and service of food
Hygiene of staff
Sanitary conditions

Pharmaceutical Services

Supervision of services
Control and accountability
Labeling of drugs and biologicals

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Physical Environment

Emergency power
Nursing unit
Facilities for special care
Maintenance of equipment, buildings, and grounds

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

1922

Memorandum

Date NOV 19 1985

From Richard P. Kusserow Bryan Mitchell
Inspector General

Subject Memorandum of Impending Release - Oklahoma - Review of Medicare and Medicaid Provider Certification Activities - ACN: 06-60151

To C. McClain Haddow
Acting Administrator, Health Care
Financing Administration

Attached is an advance copy of our final audit report to be issued on November 22, 1985. The report points out that substantial improvements are needed in the State's survey and certification procedures to ensure that safe and adequate care is provided to Medicaid recipients.

A significant number and type of deficiencies were found in intermediate care facilities (ICFs). For example, half or more of the 360 ICFs surveyed by the State were found deficient in (1) keeping resident living areas clean and in good repair, (2) handling food under sanitary conditions, or (3) handling drugs and biologicals. Moreover, many of these deficiencies were permitted to continue year after year. (See discussion starting on page 6 of the report.) For 11 randomly-selected facilities, we found that 40 percent of the deficiencies identified by the State survey agency continued to exist in at least 3 of the 4 years covered by our review.

Although State survey agency and Regional HCFA officials generally concurred with our findings and procedural recommendations, (see pages 13 and 14 of the report), we question whether conditions will improve without aggressive HCFA involvement at both the Regional and Central offices.

For example, we are particularly concerned with statements obtained from State survey officials that no one wants to cite ICF administrators as deficient because of pressures that would be brought against the surveyor. (See discussion starting on page 12.) Such statements lead us to question whether the fear or threat of pressures results in the reluctance to identify and report serious deficiencies in certain facilities.

We therefore believe there is a need for HCFA to take prompt and decisive action to resolve the findings identified in our report. We recommend that you direct the Regional Administrator to closely monitor corrective actions promised by the State survey agency. We also recommend that HCFA conduct its own special study of survey and certification activities in the State of Oklahoma, and consider exercising the Department's authority to conduct "look behind" reviews in those facilities identified as warranting such reviews.

We would appreciate being advised within 60 days of actions you plan to or have initiate(d) as a result of our report.

Attachment

For further information, contact:

Glyndol J. Taylor
Regional Inspector General
for Audit, Region VI
FTS 729-8414

Review of Medicare and Medicaid Provider Certification Activities

Oklahoma State Department of Health

REGION VI

NOTICE

The designation of financial and/or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS Office of Inspector General. Final determination on these matters will be made by authorized officials of the HHS operating divisions.

Audit Control Number: 06-60151

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit
Regional Office VI
1100 Commerce Street, Room 4E1
Dallas, Texas 75242

NOV 22 1985

Audit Control Number: 06-60151

Joan K. Leavitt, M.D.
Commissioner of Health
Oklahoma State Department of Health
1000 N.E. 10th
Oklahoma City, Oklahoma 73152

Dear Dr. Leavitt:

Enclosed for your information and use is a copy of an OIG Office of Audit report titled, "Review of Medicare and Medicaid Provider Certification Activities, Oklahoma State Department of Health." Your attention is invited to the audit findings and recommendations contained in the report. The below named official will be communicating with you in the near future regarding implementation of these items.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), OIG Office of Audit reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act, which the Department chooses to exercise. (See Section 5.71 of the Department's Public Information Regulation, dated August 1974, as revised.)

To facilitate identification, please refer to the above audit control number in all correspondence relating to this report.

Sincerely yours,

Glyndol J. Taylor

GLYNDOL J. TAYLOR
Regional Inspector General for Audit

Enclosure

Direct reply to:
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INTRODUCTION

BACKGROUND

The Social Security Act (Sections 1864 and 1902) authorizes the Secretary of HHS to contract for the services of State agencies to determine whether health facilities meet the requirements for participation in the Medicare and Medicaid programs. In Oklahoma, the State Department of Health (OSDH) is the State survey agency responsible for performing annual certification surveys of participating facilities. At the Federal level, the Health Care Financing Administration, Department of Health and Human Services (DHHS), is responsible for administering the Medicare and Medicaid provider certification program. The State and Federal participation requirements consist of a series of health and safety standards which measure the ability of an institution to render adequate and safe care. Certification surveys consist of (1) health and sanitation requirements which are evaluated by the survey agency and (2) life safety code requirements which are evaluated by the State Fire Marshal's Office -- under contract with the OSHD. Facilities not in full compliance with the health and sanitation and the life safety code requirements may be certified for a limited period under both programs, but only with an approved plan for correcting deficiencies noted during the survey. Medicare and Medicaid regulations also provide for automatic cancellation of a facility's certification if deficiencies noted have not been corrected within the time period specified in the plan of correction. During the period of our review, OSDH was responsible for certifying some 360 intermediate care facilities (ICFs), 102 hospitals, 9 skilled nursing home facilities (SNFs), 84 home health agencies, 47 independent laboratories, and 34 other miscellaneous health providers.

SCOPE OF AUDIT

Our review was made in accordance with standards for governmental auditing and included interviews with responsible officials and a review of documentation relating to State surveys of hospitals, ICFs, SNFs, and home health agencies. The ICFs and the one SNF reviewed were selected by both judgmental and statistical sampling methods. Our revi primarily directed towards ICF certification activities because preliminary audit work indicated more of a problem with these facilities remaining in compliance with Medicaid standards. Our sample included 17 ICFs reviewed in a prior audit of State certification activities (ACN: 06-02100, issued in June 1980), 11 additional ICFs, and 1 SNF. Our review, which covered surveys performed during the four fiscal years ended September 30, 1983, was performed at the offices of the OSDH in Oklahoma City, and at six ICFs in various communities in Oklahoma.

HIGHLIGHTS OF AUDIT RESULTS

Although State survey agency officials are pursuing the goal that every ICF reaches the level of care required by Federal standards, substantial improvements are needed in existing procedures to ensure that safe and adequate care is provided to Medicaid recipients.

During the 4-year period of our review, over $660 million in State and Federal funds was spent for care of Medicaid recipients in Oklahoma's 360 ICFs. To assure that such ca meets the Federal standards for quality and safety, the State survey agency received over $1.2 million during the same period to conduct surveys and certify that ICFs, SNFs, and hospitals meet the Federal standards of participation in the Medicaid program. Despite these expenditures and the State survey agency's efforts, ICF survey information disclosed that significant deficiencies existed in both the safety and quality of care provided to Medicaid recipients in Oklahoma's ICFs.

For the period reviewed, the State's surveys of the 360 ICFs show, on the average that:

-- 60 percent of the ICFs were found deficient in keeping resident living areas clean and in good repair as required by Federal standards;

-- 51 percent were cited as not meeting the Federal standards for handling food under sanitary conditions;

-- 50 percent were cited as not meeting the Federal standards for handling drugs and biologicals;

-- 39 percent were cited as not meeting the Federal standards for menu planning and nutritional adequacy;

-- 34 percent were cited as not meeting the Federal standards for administering medications; and

-- 27 percent were identified as not properly documenting signs and symptoms of illness in patient records in accordance with Federal standards.

Although the number and types of deficiencies found in the ICFs are significant, it is equally significant that many of the deficiencies were permitted to continue year afer year. For example, we found that 40 percent of the deficiencies identified by the State survey agency in 11 randomly selected

ICFs continued to exist in at least 3 of the 4 years covered by our review. Failure to take prompt corrective action is attributed to the following.

- Some State survey agency staff believed that the exact same deficiency involving the exact same people must exist to constitute a recurring deficiency.
- Surveyor statements of deficiencies provided to ICFs did not clearly identify the deficiencies or identify what needed to be done to correct those deficiencies.
- The State survey agency accepted plans of correction from ICFs that did not specifically state how or what corrective action would be taken. In many instances, the plans were nothing more than the provider's pledge to correct the deficiencies.
- Surveyor staff interviewed were reluctant to cite ICF administrators for not taking corrective action. They perceived that pressure would be brought to bear if they took a tough stand against administrators. They also felt that it would be difficult to defend their actions because of subjective judgments involved in such actions.

In addition, the State survey agency needs to improve its inspection practices to ensure that adequate staffing is maintained to provide quality care to all ICF residents. Federal survey procedures provide for the review of time sheets to verify that adequate staffing existed during the period reviewed. However, State surveyors generally test payroll records and time sheets for only the most recent 2-week period and only when a review of the ICF staffing plans indicates inadequate staffing. This method of limited testing does not provide adequate evidence that appropriate staff is maintained at all times.

Although State surveys were identifying tangible deficiencies, substantial improvements are needed to ensure that deficiencies are adequately reported and that permanent corrective action is taken.

We recommend that the State survey agency redefine what constitutes a recurring deficiency and strengthen its procedures to fully describe deficiencies found, their cause, and recommended corrective actions when communicating survey results to ICF officials.

Also, we recommend that survey procedures be extended to ensure that adequate staffing exists at ICFs at all times. In addition, we recommend that the State survey agency require specific corrective action plans from the ICFs and that follow-up visits be used to ensure that deficiencies are corrected timely and permanently as a condition for participation in the Medicaid program.

State survey agency officials, at the audit exit conference, generally concurred with our recommendations. During this conference, these officials acknowledged that improvements are needed, but pointed out that since the period of our audit, a new management team is in place and many changes have already been made. In their written response to our report, agency officials stated that inservice training is currently being conducted to improve the skills and methods of conducting surveys and writing deficiency statements. This written response, also, contained their course of action for each of our recommendations. Although the State survey agency was generally responsive to our recommendations, we believe certain actions, in addition to those described in their written response, are needed to ensure that substantial improvements are realized in the safety and quality of care provided Medicaid recipients in ICFs. For a complete discussion of the State survey agency's response to our recommendation and our comments see pages 14, 15, 16 and 18 of this report. (A complete text of the State survey agency's written response is included as an Appendix to this report.)

FINDINGS AND RECOMMENDATIONS

The State survey agency needs to strengthen its practices and procedures to ensure that (1) deficiencies reported at ICFs are permanently corrected, and (2) adequate medical and care staff are on duty. For the most part, the State agency's surveys were identifying tangible deficiencies. However, improvements are needed in all aspects of the survey process before substantial progress can be realized in the quality and safety of Medicaid resident care in IC

RECURRING DEFICIENCIES

Although the State survey agency identified numerous deficiencies at ICFs -- for the 4-year period covered by our review, an average of 7 deficiencies per ICF was reported -- these deficiencies often did not remain corrected and recurred year after year.

The State's surveys of ICFs for the 4-year period show, on the average, that:

- 60 percent of the ICFs did not meet the Federal standards for keeping the living areas clean and in good repair;
- 51 percent did not meet the Federal standards for handling food under sanitary conditions;
- 50 percent did not meet the Federal standards for handling drugs and biologicals;
- 39 percent did not meet the Federal standards for menu planning and nutritional adequacy;
- 34 percent did not meet the Federal standards for administering medications; and
- 27 percent did not properly document signs and symptoms of illness in the patients' records.

Our analysis of deficiencies at 11 randomly selected ICFs showed that 40 percent of the deficiencies reported by the State survey agency as not meeting the Federal standards of participation were cited as deficiencies in 3 of the 4 years surveyed. The following table shows the results of this analysis.

ICF #	Total Number of Deficiencies Reported	Number of Deficiencies Occurring in at Least 3 of 4 Years Reviewed	Percentage
1	15	5	33
2	11	7	64
3	8	4	50
4	12	0	0
5	9	4	44
6	9	6	67
7	0	0	0
8	7	3	43
9	1	0	0
10	2	1	50
11	4	1	25
	78	31	40%

In our opinion, the State survey agency's strict definition of a recurring deficiency is an important factor contributing to the large percentage of recurring deficiencies. According to certain State survey agency staff, the exact same deficiency involving the exact same people must exist as previously identified before a deficiency is considered as recurring. Such a strict definition permits the same basic problem to continue year after year while appearing each time as a newly identified deficiency, thus permitting recertification without correcting the basic problem. In our opinion, when the same general type of deficiency continues to occur, it should be treated as a recurring problem in an effort to correct it, rather than relying on a technicality to classify it as a non-recurring deficiency.

In addition, we believe that recurring deficiencies can be attributed, in part, to the State survey agency's:

- -- statements of deficiencies that are provided to ICFs which are unclear with respect to the nature of the problem, its significance, and corrective action needed,
- -- acceptance of plans of correction that do not adequately address the action needed to prevent the deficiency from recurring, and
- -- reluctance to cite ICF administrators who will not take appropriate action to correct recurring deficiencies.

Statements of Deficiencies

Improvements are needed in the preparation of statements of deficiencies by surveyors to ensure a full understanding of the nature and scope of problems found at ICFs and the action needed to fully correct the problems.

The HHS State operation manual identifies the attributes to be included in a statement of deficiency as specific identification of the problem, quantification of the problem, the severity or degree of the hazard of the problem, and a statement of the action needed to remedy the problem. However, our review of statements of deficiencies prepared by the surveyors disclosed that in many instances the statements lacked one or more of these attributes as illustrated in the following examples.

A surveyor identified a deficiency in menu planning and nutritional adequacy at one ICF for 3 consecutive years. The statement of deficiency for the first year read:

> Therapeutic diet menus are not followed in all instances.

The same deficiency for the second year stated:

> Some of the therapeutic diets were not served according to the planned and approved therapeutic menus.

The statement of deficiency for the third year indicated a deterioration of the condition to the extent that certain prescribed diets were not included on the menus. The statement read:

> There was no planned therapeutic menus for the following diets prescribed:
>
> 1. Low Salt, High Protein, Low Carbohydrate;
>
> 2. High Fiber
>
> 3. 1,200 Calories, 1,000 Milligrams Sodium Strict

The first two statements of deficiencies did not specifically identify the problem, its severity, proportion of residents affected, and the action needed to correct the problem. Although the last statement was more specific as to the nature of the problem, no additional information was given. The lack of information regarding the problem may have been a factor as to why the deficiency continued to occur during the 3-year period.

Another example of an inadequate deficiency statement, dealt with a drug administration deficiency. This deficiency statement initially read:

> -- Documentation in the resident's record is inadequate for PRN drug administration.

The next year this deficiency statement read:

> -- The facility was not consistently following its policy on documentation of as needed (PRN) medications.

In the third year, the deficiency was again identified and the deficiency statement read:

> -- Numerous unexplained blanks were observed on the medication administration sheets.

The deficiency as cited did not specifically identify how the documentation was inadequate and did not quantify the extent of the problem. None of the deficiency statements for the 3-year period specifically identified the action needed to remedy the problem. Additionally, the significance of the deficiency and the degree of hazard to the health and safety of residents were not described.

To further illustrate, the elements of the resident record keeping system for one ICF were found deficient during a 3-year period. The first year deficiency statement read:

> -- Pertinent information regarding the improvement or deterioration of wounds, decubitus, and abrasions needs to be documented periodically in the resident's records.

In the following year, the deficiency statement read:

> -- On one record reviewed there were no vital signs recorded after the resident fell out of bed. Also, there was no documentation of any action taken or further observations of the resident. On the same record, another fall recorded on an incident report was not documented at all on the nurses notes or progress notes.

For the third year, the deficiency was again cited and read:

> -- Incident reports were not documented in the nurses notes on a consistent basis and some do not have adequate follow-up data as to the action taken.

Again, the quantification of the problem, the degree of hazard, and the action needed to remedy the deficiency were not provided. Without such information, it is difficult to determine the significance or the cause of the problem. Until these attributes are identified, meaningful correction may not take place.

State survey agency personnel acknowledged that all attributes may not be identified in the statement of deficiency. State agency surveyors indicated that many of the underlying causes of the deficiency are complex and not easily understood. Because of these complexities, previous deficiency statements had become voluminous. According to State survey agency officials, ICF operators were worried that prospective clients would compare deficiency statements from several facilities and would automatically reject a facility with the most voluminous deficiency statement. Since the deficiency statements are available to the public under public disclosure regulations, and since the volume of the deficiency statement may address the complexity of the problem rather than the significance of the problem, the State survey agency agreed with the nursing home operators that voluminous deficiency statements would not be a way to fairly evaluate ICFs. As a result, surveyors were told to write terse, but complete, statements of deficiency.

Surveyors stated that they were told to be less descriptive in preparing statements of deficiencies. Also, they said that this had caused problems because nursing home administrators and staff did not always understand the deficiency or the action needed to remedy it even though a complete oral presentation was made at the time of completion of the on-site survey. Also, according to one surveyor, personnel assigned to make a follow-up review to verify that deficiencies have been corrected may not know the full extent of the problem and, therefore, fail to detect uncorrected deficiencies without performing another full review of the problem area.

We believe that comprehensive statements of deficiencies, including all attributes required by the State operations manual, would provide all parties, including the public, with better information and would provide a basis for actions to fully correct the deficiencies.

Plans of Correction

The State survey agency should require more definitive correction action plans from ICFs which specify the actions that will be taken to permanently correct the basic cause of the identified deficiency. The State operations manual identifies several purposes of plans of correction which include the following.

- -- n aide to the survey agency in following activities to ascertain progress and assist the facility in carrying out its commitments to come into compliance with Medicaid conditions of participation.

- -- The basic document to be disclosed to the public inquiring about the facilities deficiencies and what must be done to remedy them.

- -- Support for future termination proceedings if this becomes necessary.

- -- The administrator's statement as to pending and promised correction efforts, which he enters on this signed document, are important to the evaluation of health and safety issues.

Federal regulations, Title 42, CFR, Part 442, Subpart C, Section 442.105, allow the certification of facilities with recurring deficiencies provided that the facility was unable to stay in compliance with the standard for reasons beyond its control, or despite intensive efforts to comply. The plan of correction developed to support recertification of an ICF where recurring deficiencies are involved should clearly define the procedures that the provider intends to implement to comply with the standard.

In many instances, plans to bring ICFs with recurring deficiencies into compliance with Medicaid standards were nothing more than pledges to correct the particular problems identified by the State survey agency, or statements that the problems had been corrected. For instance, the plan of correction submitted by the ICF and accepted by the State survey agency to correct the menu planning problem previously discussed (see page 8) consisted of the following statement.

> The therapeutic menus for the ones listed have been planned and written and are included in our therapeutic program.

It should be noted that the above statement pertained to only the three prescribed diets identified in the statement of deficiency, although problems in this area were identified in the two preceding surveys. The plan of correction was incomplete because it did not provide for any action to correct the underlying cause of the problem to prevent it or a similar problem from recurring in the future. No assurance was given that all diets prescribed in the future would be prepared and served to the respective residents of the ICF. According to the State survey agency's definition of a recurring deficiency, as previously discussed, any change in the conditions such as a change in residents affected by the continuing deficiency would prevent the same basic problem from being identified as a recurrring deficiency in the following year.

In our opinion, and in accordance with the State operations manual, the State survey agency should require plans of correction which specify the actions that will be taken to permanently correct the basic cause of each identified deficiency.

Administration of ICFs

Despite the number of deficiencies being reported by the State survey agency at ICFs and the significant number of recurring deficiencies at many ICFs, the State survey agency rarely cited the administrator of an ICF for not taking correction action. For the 4-year period, less than two percent of all ICF administrators were cited as being deficient. No administrator deficiencies were reported for the last year of our review.

Title 42, CFR, Part 442, Subpart C, Section 442.105 states that if the facility has the same deficiency as it had under the prior certification, the agency must document that the facility:

> (1) did achieve compliance with the standard at some time during the prior certification period, (2) made good faith effort ... to stay in compliance, and (3) again became out of compliance for reasons beyond its control.

The CFR also requires an ICF to have an administrator to ensure ICF compliance with Medicaid standards. One section of the survey form used for certification deals with the administrator of the facility. However, officials of the State survey agency stated that they did not attempt to document efforts by the administrator of an ICF with recurring deficiencies to stay in compliance because of the additional survey time required. Also, if efforts were made to document such an attempt only to find that no attempt was made, the surveyor would be required to cite the administrator as deficient. According to State survey officials, no one wants to cite an administrator as deficient because of the pressures that would be brought against the surveyor.

One surveyor told us that any surveyor who cited an administrator for not properly managing the ICF would be required to justify the action in conference with the administrator of the ICF, the administrator's lawyer, and the Commissioner of Health. Since management concepts are subjective, it is most difficult for the surveyor to adequately document and justify these types of deficiencies, and that little of a positive nature would come from such conferences. Certain surveyors indicated that if a surveyor insisted on being tough on administrators, the surveyor could be transferred to another area.

Because of this perceived pressure, nursing home administrators with poor performance records were allowed to continue to operate in the Medicaid program without penalty. One State survey agency official told us of instances where administrators are often absent from the ICF and provide little effective management at their facilities. Another official stated that certain administrators are rarely at the facility, are relatively unknown by the residents or staff, and have little knowledge of how the facility is actually operating.

Although State survey agency personnel acknowledge that many administrators are deficient in taking corrective action to alleviate continuing problems at ICFs, few administrators are actually cited for such deficiencies since surveyors believe that few positive results would come from such actions.

Recommendations

In order to ensure that deficiencies at ICFs are properly identified and permanently corrected, we recommend that the State survey agency:

(1) Redefine "recurring deficiency" to ensure that when a facility is out of compliance with a particular Medicaid standard for two or more years, it is in fact considered a recurring deficiency.

(2) Prepare statements of deficiencies that conform to the criteria identified in the State operations manual. Deficiency statements should specifically identify the facilities' deficiencies in meeting Medicaid standards, quantify the extent of the deficiencies, identify the underlying causes of the deficiencies, and describe the significance of the deficiencies or the degree of the hazards to the health and safety of the ICF's residents.

(3) Require that ICFs prepare plans of correction which clearly define the procedures that the provider intends to implement to comply with the standard. This would include specific steps the provider plans to take to preclude the deficiencies from recurring.

(4) Require the provider with recurring deficiencies to demonstrate that the facility was unable to remain in compliance for reasons beyond its control or despite good faith efforts to comply.

(5) Take definitive action against ICFs who continually operate in an environment of recurring deficiencies, cite such ICFs' administrators for deficiencies, and, if warranted, refer administrators to the Oklahoma State Board of Nursing Homes.

(6) Actively support and encourage surveyors to cite administration deficiencies in those cases where an ICF continually has recurring deficiencies.

State Survey Agency Comments and Office of Audit Response

At the audit exit conference, State survey agency officials generally agreed with our recommendations. These officials stated, however, that subsequent to the period of our audit, a new management team had been placed in charge and substantive changes had been or were in the process of being made. In their written response to our report, State survey agency officials stated that inservice training is being conducted routinely to improve the skills and methods of conducting surveys and writing statements of deficiencies. Also, in their response, State survey agency officials outlined their course of action for each of our recommendations. Following, is a brief synopsis of the State agency's comments regarding each of the six recommendations. (A complete text of the State survey agency's comments is included as an Appendix to this report.)

Recommendation (1) - State survey agency officials outlined their present policy by stating that a deficiency is now considered recurring when a facility is out of compliance with a particular Medicaid standard for two or more years. They further clarified their present policy by providing an example which illustrated that a deficiency [illegible] not have to be the exact same deficiency to be considered recurring.

Recommendation (2) - State survey agency officials agreed to specifically identify deficiencies on the statements of deficiencies in accordance with provisions of the State Operations Manual.

Recommendation (3) - e survey agency officials out-
d their current procedures
stating that now the agency
es require the administrator to
clearly define the procedures to be implemented to comply with the standards. Informal conferences are conducted in which the facility's representatives are instructed how to reply to statements of deficiencies. In many instances, plans of correction are rejected when the facility has not clearly defined its actions. Further, a more thorough review process has been initiated to ensure that there will be fewer recurring deficiencies.

Recommendation (4) - State survey agency officials stated that the agency will require better documentation to ensure that previously cited deficiencies do not recur.

Recommendation (5) - State survey agency officials did not specifically address this recommendation other than stating that they were not required by law to take action against administrators.

Recommendation (6) - State survey agency officials, again, outlined their present policy by stating that surveyors are encouraged to cite all existing deficiencies, whether those deficiencies be initial or recurring.

With regard to the first three recommendations, the actions described by the State survey agency officials, if properly implemented, should result in improvements in the survey process. However, for substantial improvement to be realized in the safety and quality of care provided in Medicaid ICFs, we believe additional steps may be necessary, regarding the last three recommendations.

First, regarding the fourth recommendation, while we agree that better documentation is needed, we believe that a significant change in survey procedures will be necessary before the State survey agency will be able to document that the facility was unable to remain in compliance for reasons beyond its control and despite good faith efforts to comply. We believe our recommendation will require additional efforts on both the part of the State survey agency and the provider.

Regarding the fifth recommendation, we would reiterate that definitive action must be taken against ICFs who continually operate in an environment of recurring deficiencies if tangible improvements in safety and quality of care are to be realized. We believe this is of paramount importance and must be addressed. We agree with the statement that State survey agency officials are not required by law to take action against administrators. Nevertheless, neither are they prohibited from citing administrator deficiencies [illegible] referring such administrators to the Oklahoma State Board of Nursing Homes. We believe this would be an effective deterrent to those administrators who operate in an environment of continuing recurring deficiencies.

Finally, with regards to our sixth recommendation, we recognize that the State survey agency encourages surveyors to cite all deficiencies. However, certain surveyors whom we interviewed perceived that pressure would be brought to bear if administrator deficiencies were cited. If surveyors were provided active support in writing up such deficiencies, we believe this perceived pressure would no longer exist.

VALIDATION OF STAFFING

State agency surveyors need to improve their survey practices to ensure that adequate staff is on duty to carry out the ICFs' responsibilities to their residents. In a previous review we found that the State agency surveyors were only testing staffing plans to ascertain if staffing requirements were met. As a follow-up to that review, we performed limited tests and found that generally, surveyors still only review the ICF's staffing plan to determine if adequate staffing exists. Only when the staffing plan indicates discrepancies does the surveyor test payroll records or time sheets. Also, only the most recent 2-week period at the time of the site visit is checked.

Federal survey procedures, as outlined in the *Interpretive Guidelines and Survey Procedures for the Application of Standards for the General Intermediate Care Facilities*, include a step to check time sheets for all tours of duty to verify the consistency of staffing. Since staffing is one of the most critical elements in assuring the quality of care to ICF residents, we believe definitive steps must be taken during the survey to determine if adequate staffing is maintained.

If only the staffing plan is reviewed, as is currently being done in most cases, there is no assurance that the plan was followed and that the prescribed number of staff were actually on duty. Also, if only the most recent 2-week period is checked, there is little assurance that adequate staffing was maintained throughout the period.

Federal investigations conducted at two ICFs by the Office of Inspector General, prior to this audit period, disclosed that the staffing plans and the time actually worked did not agree. Although both of these ICFs had undergone certification surveys with no problems recorded as to staffing, the investigations disclosed that both of the ICFs had insufficient staff on duty to meet State and Federal requirements. If payroll records and time sheets had been checked during the surveys, the problem most probably would have been identified. However, since the surveyor only tested these facilities' staffing plans, no problems were reported.

Our current review of this area was limited to identifying that staffing plans were still being used as the principle means to verify staffing requirements. In addition, we found no convincing support that staffing plans represented actual time worked.

Recommendations

We recommend the State survey agency require that surveyors validate, on a sample basis, facility staffing to employee time records and other payroll records when appropriate, and require corrective action if time records do not demonstrate the validity of staffing plans. The testing of staffing patterns should not be limited to only the most recent 2-week period at the time of the site visits, but should be made throughout the survey period to ensure that adequate staffing is being maintained.

State Survey Agency's Comments

State survey agency officials agreed with the above recommendations and stated that surveyors will validate, on a sample basis, quarterly time reports and other records. (A complete text of the State survey agency's comments is included as an Appendix to this report.)

OTHER MATTERS

SUPERVISION OF HEALTH SERVICES

During our review, officials of OSDH expressed concern that health services were being provided in Oklahoma ICFs without supervision from licensed charge nurses. This concern stems from the fact that many Oklahoma ICFs employ Certified Medication Aides (CMAs) to supervise their second and third shifts of operations. These officials told us that they believed these CMAs do not have the training or experience to exercise the judgment necessary to provide health services, such as treatments, medications, diets, etc., without direct supervision from a licensed nurse.

Our analysis of data from a random sample of 11 ICFs for fiscal year 1983 confirmed that many ICFs had CMAs in charge during the second and third shift. This sample also showed that health services were being provided during these shifts. For example, data from our sample showed that 25 percent of the residents were provided medications on night shifts and that 80 percent of the time a licensed nurse was not on duty to supervise the CMAs dispensing the medications.

Title 42, CFR, Part 442, Subpart F, Section 442.338, is specific in requiring ICFs to provide supervised health services for each resident. Section 442.339 paragraphs (a) through (d) also is specific in requiring that this supervision must include a health services supervisor who is registered nurse, a licensed practical nurse, or a vocational nurse to supervise the ICFs health services full time, seven days a week, on the day shift. However, regarding the second and third shifts, paragraph (e) of this regulation permits the facility to employ as a charge nurse an individual who is licensed in a category other than a registered or licensed nurse, provided the individual has completed a training program to get the license which includes at least the same number of classroom and practice hours in all nursing subjects as in the program of a State approved school of practical or vocational nursing.

OSDH officials expressed doubt that CMA training would meet the Federal criteria cited above. They also provided a letter from officials of the Health Care Financing Administration, dated November 30, 1977, which stated that it was not the intent of Federal regulations to replace licensed nurses with medication aides, as these people have neither the training nor education to replace licensed nurses. Nevertheless, OSDH officials have not enforced their interpretation regarding the qualification of CMAs to act as supervisors at ICFs because of, as they state, (1) the ambiquity of the Federal regulation, and (2) the State's policy regarding Medicaid payments to ICFs.

Within the State of Oklahoma, the State Department of Human Services (DHS) is responsible for making Medicaid payments to ICFs. In addition to ICFs meeting the Federal certification requirements, DHS has established fee schedules for ICFs based on specific staffing requirements. These requirements include a full-time licensed nurse on duty during the day shift 7 days a week, a minimum of one licensed nurse for every 25 patients with coverage required on no more than two of the three daily shifts, and a minimum of one CMA on any shift not covered by a licensed nurse.

OSDH officials stated that the staffing requirements spelled out by DHS are the basis for payments to ICFs; therefore, providers have argued that they are not being paid to furnish licensed nurses on all shifts.

Federal standards for ICF care, in our opinion, were written to allow ICF providers freedom from a narrow interpretation of requiring licensed nurse supervision on every shift without consideration of the health services needed by residents. We believe Federal regulations require that health services prescribed or planned for an ICF resident, without regard to the tour of duty during which it is provided, should be supervised. However, as to whether CMA training and experience qualify as meeting the requirements of supervision, we believe this is an interpretation that should be made by OSDH without consideration of the State's Medicaid payment policy.

APPENDICES

Joan K. Leavitt, M.D.
Commissioner

OKLAHOMA STATE
DEPARTMENT OF HEALTH

P.O. BOX 53551
1000 N.E. TENTH
OKLAHOMA CITY, OK 73152

AN EQUAL OPPORTUNITY EMPLOYER

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Linda M. Johnson, M.D.
Ernest D. Martin
Walter Scott Mason, III
W.A. "Tom" Taylor

June 20, 1985

Glyndol J. Taylor
Regional Inspector General for Audit
Office of Audit
Regional Office VI
1100 Commerce Street, Room 4E1
Dallas, Texas 75242

Re: Audit Control Number: 06-50151

Dear Mr. Taylor:

The exit conference, with the concurrence of Mr. Hargrove and Mr. Slay, had to be changed to 1:00 p.m., June 14, 1985.

There was considerable discussion on items pertaining to Section 3302 A and C of the State Operations Manual. We feel that better communication was brought about on actions on deficiencies required by the State Agency and use of words such as subjective and permanent. Inservice training is being conducted routinely to improve the skills and methods of conducting surveys and writing deficiencies on Form HCFA-2567.

We are enclosing our course of action to your recommendations listed on pages 13, 14, and 16.

If there are questions, please advise.

Sincerely,

Joan K. Leavitt, M.D.
Commissioner of Health

Enclosure

COURSE OF ACTION
AUDIT CONTROL NUMBER: 06-50151
INSTITUTIONAL SERVICES
OKLAHOMA STATE DEPARTMENT OF HEALTH

(1) A recurring deficiency, as defined by this Agency, exists when a facility is out of compliance with a particular Medicaid standard for two or more years. To further explain, if a deficiency is cited within the standard, such as "special diets", we expect the facility to submit a plan of correction to include a proposed action to ensure proper serving of all diets ordered. When the facility is surveyed the next year, if a dietary deficiency is cited, not necessarily the same one, the facility would be considered as having a recurring deficiency.

(2) The Agency will specifically identify the facility's deficiencies and quantify the extent of the deficiencies, following the examples outlined in the State Operations Manual Section 3302C dated April, 1980.

(3) The Agency does require the administrator to clearly define the procedures to be implemented to comply with the standards. We conduct informal conferences in which the facility's representatives are instructed how to reply to statements of deficiency. In many instances, plans of correction are rejected when the facility has not clearly defined its actions. A more thorough review process has been initiated to ensure that there will be fewer recurring deficiencies.

(4) The Agency will require better documentation to ensure that previously cited deficiencies do not recur.

(5) This Agency is not required by law to take action against administrators.

(6) We encourage surveyors to cite all existing deficiencies, whether it be initial or recurring.

The surveyors will validate, on a sample basis, quarterly time reports and other records.

REPORT DISTRIBUTION SCHEDULE

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Other Parties	
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Joan K. Leavitt, M.D. Commissioner of Health Oklahoma State Department of Health 1000 N.E. 10th Oklahoma City, Oklahoma 73152	2
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Director, Health Care Financing Audit Division	1
Regional Office	2
	10

National Citizens' Coalition for
NURSING HOME REFORM
1825 Connecticut Avenue, N.W.
Suite 417B
Washington, D.C. 20008
202-797-0657

Freda E. Gorrecht
President

Elma L. Holder
Executive Director

November 26, 1985

Sidney Katz, M.D., Chairman
Associate Dean of Medicine
Box G
Brown University
Providence, Rhode Island 02912

Dear Dr. Katz

This letter requests a copy of the latest revision of the report completed by the Nursing Home Regulation Committee of the Institute of Medicine, as established in the government contract between the Health Care Financing Administration (HHS) and IOM.

We realize that to become an official document, the Academy of Sciences must give its final approval of the report. However, we believe it is critical that the study information be made available immediately to those agencies and organizations participating in and responding to critical issues affecting the nursing home regulatory system:

1) As you know, HCFA has issued a proposed rule, October 31, 1985, requiring public response by December 30, 1985. This is the first major public proposal on quality assurance in nursing homes in three years and one that demands serious public attention.

2) Smith v. Heckler requires, or at least influences, immediate HCFA/HHS response and action to improve the regulatory system and to assure the Medicare/Medicaid beneficiaries receive quality care.

3) NCCNHR has numerous requests from Congressional offices which are in the process of developing legislative proposals on issues addressed by the IoM Committee: specifically, quality assurance; patients' rights; the long-term care ombudsman program; and federal requirements for Inspection of Care.

In order for all concerned and interested parties to respond in the most timely, responsible, and knowledgeable manner to these important activities and directions, the information and ideas generated by the Committee are needed. We understand that internal policies and procedures require the Academy of Sciences to approve or endorse the Committee report; although, to state it frankly, the AoS endorsement of the Committee's work seems irrelevant given the current state of affairs.

We trust that you will see the importance of our request and be able to provide a copy of the full report (or at least the parts relevant to the new HCFA proposal) to our organization and other concerned parties. We want to assure the Committee that we have no interest in publicizing the material or in influencing the final copy, but will use it to make responsible consumer decisions.

/copy/

over

Page 2
Sidney Katz, M.D.

Indeed, we have purposefully honored the IoM Committee process and have never before asked anyone for even draft copy.

Now, we would greatly appreciate receiving a reply and/or copy material prior to our working session on the proposed regulations which we have scheduled December 9-11, 1985. We would also welcome participation from any Committee members who can attend the session described in the enclosed information.

As we have stated before, we appreciate the tremendous amount of hard work and time you and all the Committee members have contributed to help improve the nursing home regulatory system. It is because of the importance of your work that we make this request.

Thank you in advance for your cooperation.

Elma L. Holder
Executive Director

cc: IoM Committee members
David Tilson, IoM Staff Director
Anthony Robbins, M.D., U. S. House of Representatives
  Energy and Commerce Committee
Ruth Katz, U.S. House of Representatives, Energy and Commerce,
  Subcommittee on Health and the Environment
David Schulke, U. S. Senate Special Committee on Aging
William Benson, U.S. Senate Special Committee on Aging
Thomas Morford and Sharon Harris, Health Care Financing Administration
Robert Butler, M.D.
National Senior Citizens Law Center and other concerned
  national organizations

INSTITUTE OF MEDICINE
NATIONAL ACADEMY OF SCIENCES
2101 CONSTITUTION AVENUE WASHINGTON, D.C. 20418

December 2, 1985

Ms. Elma Holder
Executive Director
National Citizen's Coalition for
Nursing Home Reform
1825 Connecticut Avenue, N.W.
Suite 417-B
Washington, D.C. 20009

Dear Ms. Holder:

I am responding to your letter to Dr. Sidney Katz, chairman of the Institute of Medicine committee on nursing home regulation, requesting a copy of the latest draft of the report prepared by that committee.

Dr. Katz has asked me to reply to your letter because our response to your request is determined by official policies of the National Academy of Sciences and its constituent units, including the Institute of Medicine.

Under the policies of the National Academy of Sciences every report prepared by a study committee is subject to an independent review by persons not involved in the preparation of the report. This review is carried out under procedures established by the Report Review Committee representing the National Research Council and the Institute of Medicine. The primary purpose of this review is to assure that each report meets these instititions' standards of validity and objectivity. Maintenance of these standards is central to the functions served by the National Academy of Sciences in providing advice to the federal government and to the broader society. While reviewers may suggest changes to improve the report, reviewers are not to substitute their own judgement for that of the expert committee which produced the report. Any changes must be agreed to by the authoring committee.

No report can be released until this review is completed. Prior release of a draft report would undermine the integrity of the review process, which has proven to be a valuable aspect of the institution's study process. Draft copies of reports on controverisal topics are often requested prior to completion of the review process for reasons similar to those you present. I hope you will understand why the NAS cannot make exceptions to this important policy.

We, therefore, must respectfully decline your request. The report will be available in the near future when the review process is completed and we will be certain that you receive it immediately upon release.

Sincerely yours,

Charles Miller

Charles Miller
Executive Officer

cc: Dr. Sidney Katz
David Tilson
Karl Yordy

Association of Health Facility Licensure and Certification Directors

AHFLCD

December 4, 1985

Health Care Financing Administration
Department of Health and Human Services
Attention: HSQ-119-P, P. O. Box 26676
Baltimore, Maryland 21207

Dear Administrator:

The Association of Health Facilities Licensure and Certification Directors appreciates the opportunity to comment on the proposed rule relating to Medicare and Medicaid Programs; Long-Term Care Survey, which was published in the Federal Register on October 31, 1985.

As the managers in the State Survey Agencies to which devolves the responsibility for implementation of health facility survey and certification programs, AHFLCD has within its ranks virtually all of the collective expertise and experience in application of those systems at the State level. We are confident, therefore, that input from this group will be carefully considered.

We applaud and support the concept of focusing on resident needs and describing the degree to which those needs are met by the facility as a function of compliance with certification requirements. As known to us on November 15, 1985, the proposed outcome-oriented PaCS survey instrument does represent the initiation of desirable changes in the current survey process. However, as a result of considerable discussion during the November Annual Meeting, it was unanimously determined that AHFLCD support of the PaCS system as currently proposed, is contingent upon its revision to include the following elements:

(1) that the final form of any changes take into consideration recommendations forthcoming from the Institute of Medicine and other academic, contracted, or pilot project studies;

(2) that the Health Care Financing Administration publish survey forms, interpretive guidelines and general instructions and make same available for general comment as part of the Notice of Proposed Rule Making or other process prior to implementation;

(3) that the Health Care Financing Administration develop and announce detailed training plans for administrative and survey staff that will promote excellent and consistent implementation and administration of the revised process;

(4) that the proposed survey process include a sampling methodology and comprehensive standardized patient assessment procedure that will merit a high degree of confidence in survey findings and will successfully withstand critical professional and legal scrutiny; and

(5) that any proposed changes in the current survey system respect state-to-state variations existent between survey and certification activities and Inspection of Care programs and that appropriate funding is assured in the face of such changes.

The opportunity to modify the current system is welcomed and appreciated to the extent that we can participate as partners in constructive dialogue and advocate for changes that will provide for a process that will enhance our ability to measure service delivery to beneficiaries. It is our opinion that such an outcome can best be achieved by convening a work group comprised of knowledgeable consumers, providers, and regulators charged with the responsibility to discuss concerns and to develop implementation strategies commensurate with the human and financial commitments required for an undertaking of this magnitude.

Sincerely,

John J. Jarrell,
President
c/o Health Facilities Evaluation Division
West Virginia Department of Health
1800 Washington Street, East
Charleston, West Virginia 25305

cc: Fay Iudicello
Office of Information and Regulatory Affairs
Office of Management and Budget
Room 3208, New Executive Office Building
Washington, D.C. 20503

National Citizens' Coalition for Nursing Home Reform

STATEMENT AND PRELIMINARY RESPONSE TO HEALTH CARE FINANCING ADMINISTRATION

Proposed Rules, October 31, 1985, Federal Register, Vol. 50, No. 211
File Code: HSQ-119-P

The National Citizens' Coalition for Nursing Home Reform, with support from the American Association of Retired Persons, conducted an 18-hour working session to review HCFA's PaCS proposal. Participants at the last day of the session, and subsequently, the NCCNHR Board of Directors, unanimously supported the resolution which follows. The resolution calls for a 60-day extension of the comment period to provide time to review the extensive materials necessary for reorganizing the survey process - many of which have only recently become available. It is important that the public have the opportunity to review and comment on these materials, just as HCFA has provided this opportunity for participants in the working session. The resolution views PaCS as an important step in the development of a sufficient survey-enforcement system, but one that is incomplete, in its present form, and is not now usable for certification purposes. The resolution also views PaCS in the context of the nursing home system and recommends significant changes in the total regulatory system before quality care for residents can be assured. NCCNHR urges HCFA-HSQB to continue to include consumers, providers, health care professionals, and other interested parties in the development of this system. HCFA-HSQB is to be commended for such activities thus far. A list of participants in the December 9-11, 1985 meeting is attached. (Participants who attended the final December 11 session are noted.)

RESOLUTION ON PaCS

Unanimously Supported by

Participants in the NCCNHR Work Session

December 11, 1985

and the NCCNHR Board of Directors

This resolution is passed in recognition and reaffirmation of the duty of the Secretary of the Department of Health and Human Services "to assure that standards which govern the provision of care in skilled nursing facilities and intermediate care facilities .... and the enforcement of such standards, are adequate to protect the health and safety of residents and to promote the effective and efficient use of public moneys." (as stated in Public Law 98-369, a 1984 amendment to the Social Security Act.)

According to the legislative background of this amendment, it is the intent of Congress that, "Protection of the 'health and safety of residents' and promotion of 'effective and efficient use of public monies' means that the Secretary must establish and enforce standards to achieve the goal of the Medicaid Act, that nursing home residents receive appropriate, high quality services to help individuals attain or retain capability for independence and self care."

PaCS in Context of the Nursing Home System

Assuring high quality care and services for nursing home residents requires a regulatory system with several essential components:

1) good standards of care

2) effective methods for surveying and determining the quality of service provided

3) solid enforcement procedures to eliminate bad practices and promote good ones

4) adequate reimbursement properly focused on quality care and services, accountable to public scrutiny

5) active public participation

A Consumer Statement of Principles for the Nursing Home Regulatory System, written by the National Citizens' Coalition for Nursing Home Reform and endorsed by 40 national and 250 state and local organizations, was submitted to the Secretary of the Department of Health and Human Services in September, 1983. This Statement of Principles elaborates the essential ingredients of an effective regulatory system, as follows:

1. To ensure that services are delivered to nursing home residents, the regulatory system must focus on the needs of residents
2. Standards for nursing home care must be objective, consistent, simple, and well-defined
3. The regulatory system must maintain accurate information about the quality of services provided to residents on a regular and on-going basis
4. The enforcement system should ensure that providers, as a condition of participation in the benefits program, comply with the standards agreed to in the provider agreement. The system should have a variety of methods to encourage compliance
5. The regulatory agency should assure that nursing homes spend public monies efficiently and effectively to maximize their ability to provide quality care that meets the needs of residents
6. The system shoud ensure the availability of services to those in need without discrimination on the basis of race, sex, religion, diagnosis or method of payment
7. The regulatory system should promote development of a sufficient range and supply of services, including trained personnel, in sufficient numbers to meet residents' needs.

We reaffirm the principles contained in the document, copy enclosed.

Response to PaCS

PaCS (Patient Care and Services), the inspection process proposed by the Department of Health and Human Services on October 31, 1985, addresses one important part of this total regulatory system -- how information is gathered about the quality of services residents receive. We commend its focus on outcomes of care and its direct involvement of residents in the inspection process. This proposal offers potential for improving the inspection process, and its refocus on residents makes it an important step in the right direction. Yet it remains one step, which by itself, cannot provide the changes necessary to assure high quality care and services for nursing home residents.

In its current form, the PaCS system is not yet adequate for use in making legal determinations about whether or not a facility should be recertified for Medicare or Medicaid. PaCS presents a method for gathering information and screening for problems through discussion with a sample of residents on a sample of issues. It does not, in its present form, guide surveyors sufficiently to enable them to determine where a facility is deficient or what is an appropriate plan of correction. Moreover, it does not include adequate tools for enforcement of standards of care or assurance that each individual receives appropriate and high quality care.

Before PaCS can be used for certification purposes, its forms and guidelines need to be revised and reorganized significantly to provide more guidance to surveyors on how to register deficiencies based on what they observe. The forms should retain all the Conditions of Participation, and the elements and standards, each of which should be reviewed during each survey. Each section of the guidelines should be reworked to include a rights component and a psychosocial component. A more detailed discussion of preliminary recommendations on the PaCS materials and processes, including the resident sample, is attached.

HCFA should conduct an educational campaign to promote and support residents' participation in the survey process, through development and distribution of an explanatory brochure, and coordination with local ombudsman programs in work with residents and families.

Since PaCS is an important step in the right direction, HCFA should continue its evolution and development. Testing of PaCS instruments and training in the PaCS philosophy should continue and expand, so that HCFA and state surveyors can maintain the positive momentum towards PaCS and move close to implementation of this system. Training, particularly in communication and observation skills, should be conducted by HCFA for every surveyor.

Conclusion

As HCFA-HHS maintains its commitment to PaCS and continues development and progress on PaCS, HCFA should also begin efforts to reform the rest of the regulatory system. We support the work plan of the Acting Director of the Office of Survey and Certification (see attached) and urge the Department to progress in its efforts to build a regulatory system which truly assures high quality care and services for each nursing home resident.

NCCNHR will submit more detailed recommendations specificaly on PaCS to HHS-HCFA as soon as possible. The PaCS proposal is an ambitious one, the materials are complex and sensitive. Once again, we call upon the Department to extend the comment period by 60 days in order for the public to respond to this important proposal, particularly in light of the fact that key materials for the PaCS process have only recently become available.

We commend HCFA for initiating this important refocus of the survey process and urge the Department to approach needed reform of the entire regulatory system with a similar vigor.

NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM

12-18-1985

PRELIMINARY RESPONSE TO PaCS (PATIENT CARE AND SERVICES) PROPOSAL ISSUED OCTOBER 31, 1985, by the Health Care Financing Administration, DHHS

This response incorporates the work by participants in a NCCNHR Work Session (December 9-11, 1985) and the NCCNHR Board of Directors. The work session was supported through funds from the American Association of Retired Persons.

NOTE: Detailed recommendations on the PaCS Survey Forms and Guidelines will follow. These preliminary comments summarize recommendations of participants in the December 9-11 work session, list attached. In order to respond fully and responsibly to the full set of materials made available in early December, additional time is needed in the comment period. A 60-day extension is requested.

PaCS Forms and Guidelines

The forms should retain reference to all of the Conditions of Participation, standards and elements, all of which should be reviewed at each survey. The revised forms need additional revision and reorganization. Much of the information currently contained in the guidelines should be incorporated into the forms for ready access by surveyors during the survey. Each subject area should contain an introductory section followed by itemized areas for the surveyors to examine. The forms should cross-reference any related standards and elements and should include guidelines to trigger a more in-depth review of more residents and more issues, as needed.

Each section of the guidelines should include provisions which address related residents rights and psychosocial/emotional components of care. These requirements need to be weaved into the total process rather than dealt with in isolation. Suggested interview questions should be rewritten so that they are more sensitive, more outcome oriented, and more open-ended to generate a fuller response from residents. Particularly the social services, activities, residents' rights, rehabilitation and restraints sections should be revised and restructured. Other sections, including physician and pharmaceutical services, in their current form, have little expectation of resident input; each should be revised.

Citing Deficiencies

Every problem observed should be noted on the official inspection report, requiring a plan of correction by the nursing home and follow-up by surveyors. Problems found among a sample of residents should trigger review of a larger sample of residents, particularly those who might have similar conditions and problems. Surveyors should look behind outcomes to determine their cause, and should include comments and citations about care practices and policies in the statement of deficiencies. Plans of correction should relate to the particular practices and policies which need change in order to assure correction of deficiencies.

Evaluation of the nursing home's care and services should be based on whether or not individual residents' care needs are met. Surveyors should look for the absence of positive outcomes as well as the presence of negative outcomes. When a problem relates to multiple standards and elements, all relevant regulations should be cited. Corrections of deficiencies should be verified on site.

Selecting Residents to be Interviewed

Every resident has the right to participate in the survey. Surveyors should make private time available for any resident who expresses an interest in talking to the surveyors about care in the facility. The surveyors should be available for discussion with groups of residents and with resident council as well as individual residents. Sometimes residents feel more free to speak in a group setting.

The survey sample should be enlarged to at least 20% in large facilities and 25% in small facilities. Problems among a group of residents should trigger a larger sample for further review. Guidelines for selection of the sample residents should be revised and should incorporate at least differences in the following: sources of payment, mental and physical status, race, ethnic background and nationality, as well as the residents' connection with family and friends. The resident council and any local ombudsman program can assist greatly in selection of residents to be interviewed. While facility staff can be helpful, they should not be directive; nor should they be exclusively involved in selection.

Efforts should be made to hear from representatives of those who cannot speak for themselves. Other residents, family members and ombudsmen may be able to supplement the survey process, specifically with information about less able residents. Extensive training in communication skills, particularly with persons with communication barriers, should be provided to every surveyor.

Surveyors should call upon the state and local long-term care ombudsmen or any experienced local citizen advocacy program to assist surveyors in identification of potential problems to review; identification of potential residents for interviews; and follow-up to protect residents from any form of retaliation for their participation in the survey. Protecting the confidentiality and security of every resident who participates should be a high priority for surveyors.

Just as training for surveyors will be essential to enable them to conduct the type of interviews and observations required by PaCS, residents will also need support to enable them to respond in the best possible manner. HCFA should develop an educational brochure explaining PaCS, and stating residents' rights in relation to the process. Nursing home providers and consumer organizations can assist in this task. HCFA should coordinate activities with local and state ombudsmen and experienced advocacy programs for training both surveyors and residents, and their families or other representatives.

Team Composition

To conduct a high quality (PaCS) survey, survey teams should include a minimum of 3-5 surveyors, including an RN, a social worker, and a dietician/nutritionist. If PaCS is combined with the Inspection of Care, a 100% assessment of residents should be required. The survey team should be trained to evaluate the assessment (care planning) capabilities and activities of the nursing home staff and to relate that assessment to their own patient review at the time of the survey.

552

1/4/86 To ZMS WM FYI [illegible] Termination Procedures

A. N. SHINPOCH
Secretary

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
[illegible]

December 17, 1985

CERTIFIED MAIL

RECEIVED
DEC 18 1985
DSHS BNHA
SURVEY PROGRAM

Administrator Haddow
Health Care Financing Administration
Department of Health and Human Services
P.O. Box 26676
Baltimore, Maryland 21207

Attention: BPO-045-P

Dear Administrator Haddow:

This letter presents Washington State's comments on proposed rule BPO-045-P to amend 42 CFR part 442. The proposed rule modifications are intended to preclude federal Medicaid matching for decertified nursing home facilities during extended appeals. The core change is the revocation of MSA-PRG-11 which the federal Grant Appeal Board has used in ruling that Medicaid matching is available up to 12 months after decertification when appeals or court litigation are involved. The new policy would apply even if "State law or federal or state court orders require the state to continue payment to the facility after that date."

As at present, the proposed rules would limit Medicaid matching to 90 days after decertification, if two types of exceptions were granted. A provider agreement may be extended for up to two months if the extension (1) will not jeopardize patient health and safety, and (2) is necessary to prevent irreparable harm to the facility or to patients, or (3) it is impracticable to determine if the facility is certifiable without extension. In addition, 30 days matching is permitted after the agreement has expired to facilitate patient transfers. This state's experience has been that the exceptions are granted by the regional office, when patient health and safety is not in jeopardy.

The State of Washington supports a clear federal policy which ensures uniform application of decertification regulations by all Medicaid agencies. We believe this can be achieved without the adverse effects on all parties which would occur if this proposed rule is adopted. Washington's alternate proposal is in two parts. The first is to simply permit Medicaid matching to continue for up to 90 days following decertification when patient health and safety is not in jeopardy, without the need to request exceptions. This 90-day period would include time for completing hearings. This proposal is more practical and simpler to administer and would be clear to all parties. It corrects the problem of long periods of continued federal matching after decertification due to hearings. The proposal would not change the current status except to eliminate paperwork and time involved in requesting exceptions. More important, 90 days is necessary to complete all actions relating to decertifying a Medicaid facility and relocating patients. Trying to shorten the 90-day period causes a set of problems directly contrary to the intent of the decertification regulations controlling nursing homes and due process requirements:

1. Sixty days is needed generally for facilities to correct conditions that led to decertification. A further 30 days, after the decertification date, is needed to determine if correction has been achieved or not. Washington's experience is that 60 days is needed to implement new procedures and systems to correct deficiencies and maintain compliance. Sometimes new staff must be hired and trained and specialty consultation provided. Forcing re-surveys without adequate time for correction is a poor public policy and poor utilization of scarce survey resources.

2. Sixty days is needed to permit appropriate patient relocation. Washington has a 94 percent occupancy rate in nursing homes with occupancy rates nearing 100 percent in some areas. With adequate time for planning, patients can be relocated to appropriate nearby facilities, but 60 days is needed. To force the states to relocate patients too rapidly, to avoid loss of federal matching, would cause severe hardship on the patients and their families; e.g., to force recipients to move great distances away from their families and physicians. The initial 30 days after decertification would permit time for evaluation as to whether the facility will be able to remain certified and maintain compliance. If so, there is no need to relocate patients. If not, there still would be time for orderly relocation.

The bottom-line question is what best serves the interest of patients. Our experience is that all parties -- e.g., families, physicians, consumers -- want correction with relocation being a last resort. The single 90-day matching period after decertification best serves patient interests.

In addition to the 90-day period of federal matching funds after decertification, the issue of litigation needs to be addressed. Some concerns are:

1. Lack of matching funds when the courts have intervened ignores the state/federal shared responsibility for the Medicaid program. It unfairly places the entire financial burden on the states. The state does not control the judiciary which is an independent branch of government. One can't help but wonder what impact such a policy would have on decertification actions. The system should permit states to continue decertification actions to ensure appropriate corrective action by facilities, as is presently done in Washington.

Congress intended that Medicaid be a program of shared financial responsibility between the state and federal governments. As the Supreme Court explained in Harris v. McRae, 448 U.S. at 297,308 (1980).

> The cornerstone of Medicaid is financial contribution by both the Federal Government and the participating State. Nothing in Title XIX as originally enacted, or in its legislative history, suggests that Congress intended to require a participating State to assume the full costs of providing any health services in its Medicaid plan.

2. As we understand the proposed rule, if a state is in litigatior and prohibited from relocating patients, retroactive federal matching would be available if, in the end, the court determines the facility was correct and the state agency loses. There are some exceptions, if HCFA determines the facility was not certifiable. The obvious question arises, would matching be lost if the state won its case for decertification--which appears to be the case?

3. With respect to facilities certified for both Medicare and Medicaid, the federal government makes the final decision to decertify and is responsible for hearings and related litigation initiated by the facilities. Approximately one-half the facilities in Washington are dual certified. Would the same test apply to Medicare facilities as is proposed in these regulations? For example, if a Medicare/Medicaid facility hearing and litigation process extend beyond 90 days, would the federal government pay 100 percent of costs for Medicaid patients in these facilities?

4. Another concern is the legal question of executive branch interference in the judicial branch of government. An administrative agency can not, by regulation, determine the power of the federal courts. If the court ordered an agreement extended, then under Title XIX, the federal government is required to pay the federal share. This approach directing what federal and state courts may and may not do should be raised with the national associations of judges, the National Association of State Attorney Generals, and the American Bar Association. This may help avoid unnecessary litigation in the opinion of this state's Assistant Attorney General assigned to the nursing home program.

5. The federal government, the states, and all parties should have the benefits of any recommendations pertaining to enforcement actions from the National Acadamy of Sciences Institute of Medicine report, which is due to be released soon. Final adoption of the proposed rule should be deferred, pending those recommendations.

To conclude, it is recommended that all decertification actions be filed in the federal courts. State and federal officials then could work together to ensure speedy resolution. Federal matching would be continued until the court action was resolved. In any event, state court actions would require the state to bring the federal agency into the case as an indispensible party. (See Federal Rule Citation Provision 19.) Thus, double litigation might be avoided.

Sincerely,

Conrad Thompson
Conrad Thompson, Director
Bureau of Nursing Home Affairs HB-11

CT:SO:kg

cc: Peggy Brown
Sharon Morrison
Sid Olson
Jerry Reilly
Jerry Jarrell

bcc: BNHA Program Managers
Darlene Aanderud
Marty Weller

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date DEC 18 1985

Henry R. Desmarais

From for C. McClain Haddow
Acting Administrator
Health Care Financing Administration

Subject GAO Review of the Standards Enforcement Program for Skilled Nursing and Intermediate Care Facilities — INFORMATION

To Director
Human Resources Division
General Accounting Office

Attached for your consideration is our response to Mr. Linz's request of October 29, 1985. That request took the form of a questionnaire designed to elicit an "official HCFA interpretation of the meaning and applicability of some of the regulations and guidelines" dealing with the survey and certification requirements for skilled nursing and intermediate care facilities. Our comments follow the format of the questionnaire.

Should you have any questions or require any additional information, please contact Ron Miller of the Office of Executive Secretariat on FTS 934-7490.

Attachment

cc:
Mr. James R. Linz
Group Director
Human Resources Division, GAO

GAO Review of the Standards Enforcement Program for Skilled Nursing and Intermediate Care Facilities

I. Regulation Interpretations

A.1. A deficiency is any of the requirements listed on the survey report form as "not met".

A.2. A "different" deficiency means that the basis for finding the same standard not met on a successive survey has changed. For example, T 117 requires that food be procured, stored, prepared, distributed, and served under sanitary conditions. During the survey, the surveyor may find that T 117 is marked "not met" because food is being stored on the floor. On the succeeding survey, the food is found to be stored on shelves 6 inches off the floor, but now the surveyor finds that certain foods requiring refrigeration are not properly stored. They would cite T 117 again. This would be treated as a different deficiency.

A.3. The same deficiency means, as in 2. above, that the food is still stored on the floor.

B.1. Requirements for ICFs are not clearly designated as standards or elements. However, the introductory statement to each set of requirements is the standard, with subordinate provisions being the elements. For example, T 25 is the standard and T 26, 27, and 28 are the elements.

B.2. N/A

C.1. Yes.

C.2. Yes. These regulations apply to deficiencies at the standard level. We would require a plan of correction for deficiencies at the element or factor level, with a correction date appropriate to the seriousness of the deficiency.

D.1. Yes. The regulations require non-renewal (decertification) for repeat deficiencies even if there is not a threat to patient health or safety, or diminished capacity. The regulations provide the authority to non-renew. In other words, the Secretary (Medicare) or the State (Medicaid-only facilities) may not issue the facility a new agreement following expiration of the current agreement. Termination differs from non-renewal in that it ends the agreement before its scheduled expiration date. If deficiencies pose a threat to patient health or safety, or if they diminish the capacity of the facility to furnish adequate care, termination action may be taken at any time.

D.2. No. The provision is usually used to further support adverse action that is based on substantive health or safety deficiencies that have an adverse effect on patient health and safety. Historically, legal counsel has advised against terminations based on technical violations. For example, if during consecutive surveys a facility was found to be remiss in keeping current records on staff development (T 95), action would generally not be taken to terminate. Standards are usually fairly easy to correct, meaning that providers can avoid termination action.

D.3. Yes. A SNF would be terminated whenever deficiencies exist that jeopardize the patients or diminish the capacity of the facility to furnish adequate care. We monitor the States and our regional offices to ensure that appropriate action is taken against providers having serious problems. For Medicare, failure to comply with Medicare regulations is a cause for termination (42 CFR 489.53). Medicaid SNFs are required to meet Medicare requirements (42 CFR 442.20(a)(1)).

E.1. Yes.

E.2. Medicare regulations do refer to "deficiencies". The meaning for both programs is the same. A deficiency is the failure to meet any regulatory requirement.

F.1. The purpose of this requirement is to clarify that a provider is expected to maintain compliance. In other words, the provider is expected to meet all participation requirements at the time of resurvey.

F.2. No. The standards must be met regardless of location on the survey report form.

F.3. The comparable requirement for Medicaid is 42 CFR 442.105(c). Both regulations, 442.105(c) and 405.1908(d), require that facilities meet all standards; i.e., that they maintain "full compliance". However, the regulations acknowledge that deficiencies may occur that are beyond the facility's control. Nevertheless, the same deficiency may not be found in consecutive certification surveys.

II. Acceptable Period For Correction

A. Generally yes. However each deficiency is reviewed separately to determine the appropriate amount of time to allow for correction. In most cases, a deficiency would have to be corrected in far less than a year.

A.1. No. See above for full explanation.

B.1. No. The vast majority of deficiencies usually would be corrected. However, certain deficiencies may require additional time. The deficiencies that are "carried over" are usually related to major capital improvements. Deficiencies carried over, however, should result in a "restricted agreement", as described in A.3. above.

C.1. No.

D.1. Yes. It is our policy, but as a practical matter plans of correction are tailored to the nature of deficiencies. Some deficiencies will have to be corrected within a few days; others will require 60 days; others 120 days, etc.

D.2. No. The Medicare provision establishes the rule-of-thumb. Since State survey agencies review Medicare and Medicaid facilities, they use the Medicare provision as their guide.

III. Type of Certification

A.1. No.

A.2. Yes. Repeat deficiencies are deficiencies cited in successive certification surveys. Since the prescribed sanction for repeat deficiencies is non-renewal, action would be deferred until the end of the current agreement.

A.3. No. Survey scheduling, surveyor availability, and the effect of the deficiencies on patient health and safety and the provider's history of compliance will dictate use of the "restricted" agreement. A restricted agreement, however, could be used in every case.

B.1. The intent of the "up to 60 days" provision is two fold:

a. to give the provider or facility the full amount of time specified in the plan, and

b. to provide the State and HCFA the time needed to meet all of the procedural requirements for cancelling or non-renewing an agreement. For example, HCFA must provide 30 days notice before non-renewing an agreement.

B.2. The negative effects are minimal in terms of effects on patients, since the deficiencies that caused the conditional or restricted agreements were not found to adversely affect patient health or safety. However, such action would mean that the State is violating the regulations. For Medicaid, State matching funds for the claims submitted for the facilities in question are subject to disallowance.

C.1. No.

C.2. N/A

IV. Other Matters

A. Time limited agreements and the repeat deficiency provision were found to be administratively burdensome and not necessary. Other regulations provide a firm and clear basis for terminating participation if requirements are not met. These proposals followed Congressional action to repeal the statutory basis for time-limited agreements.

B. Yes.

C.1. Yes.

C.2. Perhaps, but there would be a legal basis for terminating the facility.

D.1. HCFA does not refer to Medicaid SNFs and ICFs as providers, but rather facilities. Medicare SNFs and certain other facilities, agencies, and institutions are referred to as providers, as listed in Section 1861(U) Title XVIII of the Social Security Act. For the sake of discussion, we consider the owner to be the provider; i.e., the sole proprieter, the partners, the corporation.

a. No.

D.2. This may vary among States and it has no relevance to our Medicaid oversight responsibilities.

D.3. The owner of the enterprise or an authorized representative must be notified.

D.4. Yes, but that may not be possible in all cases. HCFA may take adverse action even if the State does not concur, in which case, HCFA will immediately notify the provider or facility.

E.1. This is included in the soon to be released manual sections. Termination may not be deferred unless compliance is achieved before the established termination date.

E.2. N/A

E.3. No.

E.4. No. A change in ownership or lessor has no effect on the termination action already in progress.

E.5. No. The facility's physical plant or location may be a contributing factor, and, therefore, must be considered.

F.1. Not necessarily. If the change in staff resolves the problem the adverse action would stop. However, the mere changing of staff would not by itself justify deferral of termination action.

F.2. No.

F.3. No. The basis must be related to the deficiency. For example, a sprinkler system was being installed, but the plumbers went on strike, or needed equipment was not available but the provider could document efforts to purchase the equipment. It could not, for example, be the failure of the Board of Directors to approve the expenditures, or the inability of the provider to secure financing.

G.1. The provider may disagree. However, the deficiency stands, as cited, until the State agency or HCFA (for Medicare) agree that it should be revised or deleted. Strictly speaking, the provider may not appeal findings, but only the adverse determination and subsequent termination action that is based on those findings. Failure to correct or to submit an acceptable plan of correction for cited deficiencies is a cause for termination.

.REGIONAL OFFICE/FOUR STATE AGENCY MANAGEMENT MEETING

Seattle, Washington
December 19, 1985

The meeting was delayed until 10:00 a.m. awaiting arrival of state representatives from Idaho and Oregon whose planes were not able to land due to fog.

Ron Hansen opened the metting and announced some agenda changes. The state representatives in attendance agreed to finish any federal items not covered today perior to the four-state meeting tomorrow, beginning at 8:30 a.m. rather than 9:00 a.m.

I. JOE ANDERSON - REGIONAL ADMINISTRATOR

Joe presented his views on some of the changes which are occurring in the health care delivery system. He categorized them into four Cs: Clustering of more health care activity organizations; Capitation of these clusters (into HMOs etc.); Competition occurring in many different forms and being explored more vigorously; Consumerism which has increased the level of awareness and criticism of health care systems. Joe also presented three current federal legislative issues all of which have a certain degree of unpredictability.

1. Budget reconciliation process

   Funds were appropriated in excess of that requested in the area of administration, e.g., for psychiatric hospital surveys. Joe predicted that Congress will seek a rescision of these monies in the 1987 budget.

2. Appropriation process

   This is complicated by reports of presidential veto and the upcoming holidays which will probably cause Congress to seek an emergency extension.

3. Gram-Rudmann

   This is potentially an immediate problem. Non of the Medicaid/Medicare administrative funds are exempt if these cuts are across the board.

II. PROFESSIONAL REVIEW ORGANIZATION - LARRY CAMP

The PROs have shifted emphasis in two areas: 1) increased monitoring of quality care issues and 2) revising the scope of work for PROs. Utilization of resources is being explored along with a formal evaluation of PRO performance and contract options. The question was raised on whether PROs will be extended to other than inpatient hospital care. There is no plan to do this.

Larry cited an example of post hopsital complications where early discharge was suspected to be the cause. Conrad reminded the group of the special PRO number which should be called when premature discharge is suspected.

III. HOME HEALTH AGENCY SURVEYS - NONA GISH

A study involving 26 states was completed in 1984 for the purpose of evaluating the utilization of services. Two-hundred eleven visits were made. The study identified and addressed budgetary problems as well as unmet patient care needs due to a lack of skilled nursing.

1. Home Visits Policy

Not all home health agency surveys include a home visit. The determination is usually made after the survey is completed and is based on the number of problems found and/or if there has been a complaint.

Overall, the evaluation was excellent. Problems noted were in areas of handwashing between patients, incomplete assessments, neuro checks not done and physician not contacted.

Nona reported that legal concerns were raised in the recent training session in Baltimore. She suggested that states develop policies regarding transportation issues and responsibilities. The patient consent form is another legal concern which needs to be remembered when surveyors accompany agencies on home visits.

Nona expressed the likelihood that doing home visits would double the survey time, causing budget problems.

IV. HCFA DIRECTION - TOM WALLNER

Tom presented a brief overview of several items:

1. The new HHS secretary is an M.D. and may have a different philosophy from the previous secretary.

2. HCFA was asked to present recommendations on how to tighten the variance between states. He cited the example of surveyor salaries which range from $11,000 to $70,000.

3. PaCS will be discussed later.

4. Use of MMACS data to improve program effectiveness. The large picture will be focused on rather than individual facilities, along with a more agressive, no nonsense attitude.

5. Alternative sanctions to be discussed later.

6. There is emphasis on monitoring of the 1864 contract by the Regional office. Tom mentioned that the term "contract" is preferable to "agreement."

7. HSQ is attempting to bring the SOM and ROM up to date. There will be closer monitoring through ROPES.

8. ROPES (Regional Office Program Evaluation Service) is a process to assure that the RO is applying national standards.

9. The Institute of Medicine study will have questionable, immediate impact, but more through long range planning.

10. The staffing evaluation is tight. As a result, HCFA is attempting to utilize available technology to survive without the staff they have had.

11. There is considerable variation from region to region regarding what constitutes an immediate threat to patient health and safety. A workgroup is studying the problem in an effort to find concise terminology to define this.

12. Psychiatric hospitals may get more and better surveyors with the increased monies allocated.

13. There is a move to bar states from surveying their own state facilities.

V. MMACS DEMONSTRATION - LINDA LEDBETTER

Mike Jessup from the Washington State Bureau of Nursing Home Affairs demonstrated through the WASH-SPIN computer project several practical uses of the computer system and MMACS data. He pointed out that three security checks have been built into access to the system's data. A portable battery pack computer unit was also demonstrated. Mike handed out a limited number of manuals.

VI. TERMINATION PROCEDURES - JOHN STILTZ

John stressed that these changes are strictly procedural, not regulatory. They will come out in two forms: SOM and procedures manual. Final printed copies will be available in mid January 1986. Training sessions will be held in Baltimore in January. The procedures, however, are effective December 23, 1986.

The ROM expands and clarifies the look behind authority. Whereas the old ROM was procedural, the new ROM deals with the authority of the federal government to take action.

Some specifics of the termination procedures include:

1. If a condition is not met, a provider cannot be in the program. If terminated, there are two tracks:
   a. fast track - if the condition poses an immediate threat to patient health and safety;
   b. slow track - if the condition is such that it limits the capacity of the provider to render adequate care;
   c. timetables for action on each track are specific and will be outlined in the manual.

The question was raised regarding whether these procedures will be distributed to providers since they have a right to know what is expected. This is not planned, but no provider would be refused if it was requested.

VII. ALTERNATIVE SANCTIONS - DON JACQUES

There is an alternative to termination which is available only to long term care facilities and only when there is a condition not met (or standard in ICF facilities) but no immediate threat to health and safety exists.

If the determination is made to apply alternative sanctions, an opportunity to correct must be given. Up to 11 months is allowed. During that time, the facility is still in the program. A one-time visit to determine correction is made. If care has deterioriated, termination would follow. If a good faith effort has been shown, the sanction is lifted.

Don reported that the RO has been assured by the central office that guidelines would be available regarding:

1. what constitutes "good faith effort"
2. when to chose alternative sanctions
3. how to apply alternative sanctions

The question was raised why all standards should be considered in an ICF facility, since there are no conditions. This is an inequity between the ICF and ICF/SNF program.

VIII. OFFICE FOR CIVIL RIGHTS AND TITLE VI CLEARANCE - GENE POLLARD

Gene outlined the scope of work and responsibilities of OCR. Periodic compliance reviews are conducted by on-site visits, project reviews (analysis of records through the mail) and compliant investigations. Additionally, pre-grant clearances (T6) are conducted on prospective Medicare providers. This is a cumbersome process which attempts to discover discrimination practices in denial of services, e.g., no provision for interpretive services for persons with language other than English or TTY for the hearing impaired.

Section 504 of the Rehabilitation Act requires that facilities develop self-evaluation policies and procedures in this area of discrimination. OCR looks at these and will approve T6 clearance if no patterns of discriminatin are found or if appropriate steps have been taken to eliminate the practice.

IX. FEDERAL MONITORING SURVEYS - NANCY ROTHWELL

The central office targets the number of federal surveys. In 1986, around 100 will be done in Region X. Forty of these will be in long term care facilities. Twenty-five percent of those must be PaCS if implemented before June 1986. In order to reach that target, some partial surveys will be done. Core conditions to be reviewed for partial surveys are: nursing services, physician services, infection control, activities, dietary, physical environment and pharmacy. Optional standards may include zeroing in on rehabilitation.

Partial surveys will be expanded into full surveys if problems are found.

The "comparative survey" has been dusted off and is being used in an attempt to identify why differences between state agency and federal surveys occur. Central office criteria for a valid comparative analysis survey is that it must be within 60 days of state agency survey.

Nancy stated that the RO disagrees with this criteria and believes the goal should be two weeks, but because of all the other targets, in reality it is probably closer to 60 days.

Fourteen home health agency surveys will be conducted in 1986 with a new focus. HCFA has flexibility on the remaining surveys. Nancy stated they wanted to gain experience in ambulatory clinics.

HCFA has attempted to define "immediate threat" in section 41.01 of the SOM. Although 11 examples are cited, Nancy stated these are still judgmental and more guidelines are needed.

X. ICF/MR EFFORTS - NANCY RUTHWELL

HCFA has been instructed to continue monitoring these facilities at the same pace as last year. Twenty-four ICF/MR surveys will be done in 1986. Of these, 100 percent of the large facilities (over 300 beds) will be surveyed, 60 percent of medium facilities (299-16 beds) and 40 percent of small (under 15 beds) facilities. Joint federal-state surveys with are encouraged.

The final regulations on Chapter 21 of the life safety code have been written but are not yet published. Under these regulations, the surveyor makes a judgment whether self-preservation capability is:

1. prompt;

2. slow;

3. impractical.

Fire protection can be influenced by the building, resident and staff. If one of these areas is deficient, compensation in another area permits the requirements of the regulationn to be met.

On November 21, 1985, new proposed regulations were signed by the secretary but Nancy could not discuss the contents since they are not official.

The meeting adjourned and will reconvene at 8:30 a.m. tomorrow.

The Regional office/State agency meetng was reconvened at 8:30 a.m. on December 20, 1985.

XI. 1864 AGREEMENT - Tom Wallner

Tom stated he had nothing to present but would open for questions. Conrad asked if there is a chance for negotiation of this contract. Tom responded that annual renewal is not planned in the foreseeable future. He stated that individual states have the option to give notice that they do not plan to renew the contract. He further commented that this 1864 "contract" will no doubt be renegotiated at the national level at some point, but not at the end of the first year. The central office feels the states are not doing their jobs and is considering not extending that contract to states. Conrad raised the point that the central office needs to be made aware of the distinction between states who are "not doing their job" and those who are doing their job but simply do not agree with the terms of the contract.

XII. PSYCHIATRIC HOSPITAL TRAINING PLANS FY 1986 - ROB HANSEN

Requirements for psychiatric hospitals are the same as those for general hospitals except that congress has added two extra conditions for psychiatric hospitals: staffing and medical records.

Lack of funds has resulted in HCFA taking over the survey process with contracted consultants.

Training of surveyors is handled by the central office.

The state is expected to use HCFA consultants for initial surveys and in state-owned hospitals.

XIII. PaCS LONG TERM SURVEY PROCESS - RON HANSEN

HCFA has published a proposed rule requesting comments by December 31, 1985. The RO will not extend the deadline. Final approval is expected by January. There has been no decision on the December 12, 1985 hearing of the Colorado lawsuit which may influence the outcome.

Ron reported that support has been expressed by consumers and associations. He also indicated that HCFA has a contract with Brown University to evaluate PaCS after implementation so that the final product will be an evolutionary one. The IOM report will have no impact on PaCS.

Conrad addressed the point on association support by making the distinction that the associations support an outcome oriented survey process but do not support implementation of PaCS at this time because of training, budgetary issues, and other concerns which have not been dealt with by HCFA. Ron next reviewed the schedules for training and allocations for Region X and solicited ideas on how to best approach the PaCS training process.

Baltimore has plans to produce training materials including video, a slide tape presentation (introduction and overview), a case study slide, a skills development video and course manuals. There is expected to be enough produced for the RO and SA.

A lengthly discussion followed with questions raised regarding who should attend the training and several possible approaches to the training dilemma. Nancy mentioned that the states were expected to take ownership in training.

Conrad again raised the issue of available resources for completion of training as is expected while still maintaining timely surveys.

No answers were submitted to the budgetary concerns raised by the state.

The next meeting was set for the month of April. Ron Hansen will contact the state representatives regarding a date certain.

The meeting adjourned at 10:00 a.m.

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REGION X
FOUR-STATE L&C DIRECTORS
QUARTERLY MEETING
December 20, 1985
Seattle, Washington

Participants:

Conrad Thompson
Eleanor Pedlow
Maureen Whitman
Sharon Morrison
Absent: Jean Schoonover

Karen Hartz
John Gerth
Ken Lewis
Marty Weller
Tom Robinson

The Quarterly Meeting of the Region X Four-State Licensing and Certification Directors convened at 10:30 a.m. in the federal building.

Four-State Representative and Alternate

A new state representative needs to be elected at this meeting. Jean Schoonover has served two years and feels it is time to share the experience. Conrad can not serve as officer of the board and as the representative of the states in the region. A new representative will give the states in Region X an additional vote at the national level.

Conrad read the responsibilities of the state representative along with some other considerations. The importance of the ability to get to board meetings and costs involved were discussed.

Nominations were opened. Maureen Whitman was nominated. Karen Hartz stated she had a travel problem, even as an alternate. In Jean's absence, Maureen reported that Jean has stated she is willing to be an alternate representative. Maureen was elected representative with Jean as alternate.

1864 Agreement

Conrad reported concerns raised at the board meeting. Discussion followed, centering on what the association can do with respect to the national issue of the opportunity to negotiate a contract.

It was agreed that the association needs to continue its emphasis with respect to the 1864 agreement and that the state representative contact the association president for the purpose of expressing the states and Region x's view that it's time to rotate the chairmanship of the 1864 agreement.

Utilization Control Legislation

Conrad handed out and discussed Washington State's draft amendment to Section 1903(g)(5) Social Security Act. The language in this amendment attempts to change the current penalty provision from 100 percent.

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DSHS BNHA
SURVEY PROGRAM

There is unanimous agreement that 100 percent compliance is not possible and, in fact, is counterproductive. It was noted that no other program is penalized for less than 100 percent compliance. The courts have recognized that a 100 percent penalty is exceedingly harsh, but have also acknowledged the federal government's authority to do it.

Conrad requested that all states share this language in an attempt to obtain sensible legislation particularly given that the current requirements are counterproductive and serve as a revenue trap for the states.

PaCS and Federal Budget Support for Training

Conrad introduced Tom Robinson, BNHA Education and Consultation Coordinator. The agenda was revised so Tom could leave before lunch.

The group concured that the training sessions for termination procedures and PaCS should be separate. Discussion on PaCS training followed up on what was discussed at the Region X meeting earlier today.

Tom Robinson outlined the given facts to date:

- HCFA will train 300 persons nationally
- Region X will have 25 slots
- HCFA will prepare a training package for use in training done by the states
- The San Diego training will include a training in how to train others

Tom suggested that a work group be formed to study the various possibilities of how to handle this training in the most efficient and cost effective manner.

Maureen felt strongly that a consistency in training between states is most important and that this would be assured by having one state representative from each state and the regional office representative conduct the training.

Sharon Morrison raised the point that individual surveyors are not necessarily capable of training others. Conrad submitted that each state decide on who is best suited to train and include botn nurse and sanitarian. This would represent eight slots from the four states out of 25 allocated. These persons then would attend training along with other surveyors from each state. This would assure that all staff in Alaska are trained and that the quality/consistency in the remaining three states is assured.

Maureen mentioned that a variety of disciplines are involved in surveys, not just nurses and sanitarians. Conrad responded that the PaCS instrument appears weak in the sanitarian area.

Further discussion led to the following decisions:

1. Assure Alaska's training needs be met in one session, using four slots at the San Diego session.

2. States will identify key surveyors as trainers. These persons will be sent to the San Diego session to be followed up by a coordination/planning session with the R.O.

3. R.O. representatives will travel to each state and work with the trainers.

John Gerth pointed out that management can be trained at the same time with this method.

Tom Robinson will relate this proposal to Region X emphasizing the state's recommendations. Tom reported back that federal representatives from Region X agreed with the recommendations from the states.

Four-State Meetings

Conrad explained to the group that this meeting was set up differently from past meetings due to federal schedules. He opened to discussion any ideas on how meetings might be conducted in the future. It was decided that as long as a joint federal-state agenda is developed prior to the meeting and there is coordination up front on most issues, it does not matter which day the state meeting is held. The group concurred that the federal agenda should allow time for the state to raise issues which come up after development of the agenda.

Termination Procedures

Sharon Morrison stated that the only thing to add to what has already been discussed by the federal representatives is that the policy of applying the same criteria to ICFs as SNF facilities, (since there are no conditions in an ICR) represents a more stringent approach to ICF facilities. Sharon agreed to draft a letter which proposes a more equitable system for Maureen, as four state representative, to send. Sharon stated she would need approximately two weeks for this.

Maureen reported a related incident which occurred last week. A look behind survey was completed and decertification using the fast track was applied. The states were not aware these termination procedures were no longer in draft form.

Conrad stated his understanding from yesterday's meeting was that states would not be expected to use the termination procedures without the materials. He suggested Oregon's experience has implications for other states in the region. It was decided that Maureen will write a letter to the R.O. requesting to use the existing procedures until training in use of the new procedures is completed. The letter will include the concern raised yesterday that expectations to meet the requirements of procedures without prior training represents poor public policy and may result in avoidable litigation pertaining to termination procedures. Mention will also be made that the draft procedures were already implemented last Friday in an Oregon facility and request that the R.O. communicate with the Central office regarding this.

Maureen will plan to have a final letter written by January 15, 1986. Any additional comments which state representatives would like included should be sent to Maureen prior to January 13, 1986.

Association Membership

Conrad reported that for purposes of the annual meeting when a region has more than one member, each region has the right to two votes. Voting must be paid members. If a member is unable to attend the meeting, a proxy should be sent so that the region does not loose the opportunity to cast what can be a deciding vote. Proxy vote authority must be in writing to be valid.

Annual Meeting in Seattle

The association's 1986 annual membership meeting will be held in Seattle October 24, 1986. This will be the first time the annual meeting has ever been held in Washington.

Conrad solicited creative ideas for how to make Region X special with emphasis on a vision toward the future. He explained two areas to be thinking about:

1. Hosting - what can we do as a region that is unique?

2. The meeting itself - is there some program we can develop that will promote a better understanding of the relationship between survey activity and the bottom line-patient care.

Conrad further related that plans are in place to have patients at the meeting. Maureen suggested meetings for providers and stated her staff has asked for a session on Ownership and Control.

Evelyn stated she is being asked about loopholes. It was suggested she refer these questions to an attorney.

Conrad will send a renewed copy of the Ownership Control Study to each of the other three states.

Next Meeting Date

A tentative date was set for Thursday and Friday, April 3-4, 1986. Tentative alternate dates are Monday and Tuesday, April 21-22. The date will be confirmed in February.

The meeting was adjourned at 1:20 p.m.

Maureen Whitman
Region X State Agency Representative

State operations manual
Provider Certification

Department of Health
and Human Services

Health Care Financing
Administration

Transmittal No. 183

Date DECEMBER 1985

REVISED MATERIAL	PAGE NO.	REPLACED PAGES
Section 2016	2-13 - 2-14.2 (4 pp.)	2-13 - 2-14 (2 pp.)
Table of Contents, Part 3	3-1 - 3-4 (4 pp.)	3-1 - 3-3 (3 pp.)
Sections 3000 - 3052	3-5 - 3-18 (22 pp.)	3-5 - 3-18 (14 pp.)
Exhibits 4A - 4B	5-25 - 5-26 (2 pp.)	5-25 - 5-26 (2 pp.)

NEW PROCEDURE - EFFECTIVE DATE: December 23, 1985

Section 2016, Readmission to the Medicare and Medicaid Program After Termination.--Expanded to provide examples of "reasonable assurance" that deficiencies which had caused a termination, a cancellation, or a nonrenewal will not recur if the institution is later approved to participate. It also discusses how the reasonable assurance concept applies in Medicaid cases.

Section 3000, Adverse Actions - General.--Explains the applicability of the adverse action procedures to the Medicare and Medicaid programs and clarifies the terms used throughout this issuance. It also discusses a protocol to coordinate with the State ombudsman network.

Section 3001, Initial Denials of Medicare Provider/Supplier Requests for Program Participation.--Paragraphs B and C are revised to instruct SAs to forward vacated actions to the RO. This section provides time limits for processing denials.

Section 3005, Basis for Terminating Provider Participation - Citations and Discussion.--Expands material dealing with terminations of Medicaid provider agreements.

Section 3010, Termination Procedures - Immediate and Serious Threat to Patient Health and Safety (Medicare).--Provides a list of examples of what may constitute an immediate and serious threat to patient health and safety and a new detailed schedule for processing terminations.

Section 3012, Termination Procedures - Noncompliance with One or More Conditions of Participation or Coverage and Cited Deficiencies Limit Capacity of Provider/Supplier to Furnish an Adequate Level or Quality of Care (Medicare).--Provides a new detailed schedule for processing terminations when the deficiencies do not pose an immediate and serious threat to patients. This procedure reflects the lesser impact on patients by allowing the provider more time to achieve compliance with the Conditions.

Section [illegible], Interruption of Termination Timetable.--[illegible] appropriate [illegible] inappropriate bases for rescinding or delaying termination action, and explains when a credible allegation of compliance justifies a reappraisal.

Section 3020, Nonrenewal or Cancellation of Time Limited Agreements for Long Term Care Facilities (Medicare and Medicaid).--Paragraph A clarifies the applicability of time limited agreements to long term care facilities. Paragraph B clarifies when nonrenewal is appropriate and discusses special timing considerations. Paragraph C defines cancellation clause, and discusses special timing and documentation requirements.

CLARIFICATION - EFFECTIVE DATE: NOT APPLICABLE

Section 3035, Provider Undergoes Change of Ownership During Termination Proceedings.--Clarifies that an ownership change after termination action has been initiated will not interrupt the termination process.

Section 3040, Reconsideration Procedures (Medicare).--Clarifies the provider's right to a formal reconsideration following denial or nonrenewal. There is no reconsideration after a termination or cancellation.

CHANGE OF EXHIBITS - EFFECTIVE DATE: NOT APPLICABLE

Exhibit 4A, Health Insurance Benefit Agreement (Medicare)—This exhibit presents the revised Provider Agreement, HCFA-1561.

PART THREE
ADDITIONAL PROGRAM ACTIVITIES

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3000. ADVERSE ACTIONS - GENERAL

follow the procedures in this part if adverse action is initiated against Medicare participating providers and suppliers. Because many Medicare providers also participate in the Medicaid program, and because the SA must follow Federal procedures when surveying and certifying providers that only participate in the Medicaid program, these procedures generally apply to both programs. Exceptions for Medicaid are noted in the text.

A. Medicare Providers and Suppliers.--Section 2002 lists the providers and suppliers of services who may qualify to participate in the Medicare program. Providers must be found to substantially meet Conditions of Participation; suppliers must be found to substantially meet Conditions for Coverage.

B. Medicaid Facilities.--A Medicaid SNF may concurrently be approved for Medicare. In such instances, Medicaid approval is contingent on the facility's compliance with Medicare requirements, but the facility must have a separate agreement with the State Medicaid agency. Intermediate care facilities (ICFs), including ICFs for the mentally retarded (ICFs/MR), only participate in the Medicaid program.

In Medicaid, all long term care facilities must have time limited agreements with the State Medicaid agency. If a SNF participates in both Medicare and Medicaid the agreements must be coterminous.

C. State Ombudsman Programs.--In order to coordinate with the State ombudsman network, establish procedures to:

1. Notify the State ombudsman of decisions to initiate proceedings to terminate, cancel or nonrenew a provider agreement;

2. Notify the State ombudsman of voluntary terminations and planned terminations including dates of closure;

3. Consider ombudsman information about situations in the facility and the credibility of provider's allegations of compliance; and

4. Share statements of deficiencies and plans of correction.

3001. INITIAL DENIALS OF MEDICARE PROVIDER/SUPPLIER REQUESTS FOR PROGRAM PARTICIPATION

An initial denial is made when, after evaluating the evidence including initial certification action, the adjudicating office - in this case the RO - finds that the requirements of law and regulation are not met. Denial is consummated in a formal written notification which explains the right to appeal.

Denials are made only when the denied party has reason to expect a decision; generally, whenever there has been an expression, written or otherwise, of interest in participating (or in expanding the scope of existing participation) or whenever a survey has been performed.

A. Authority for Adjudicating Denials.--The RO adjudicates all determinations of approval or disapproval to participate in Medicare. 42 CFR 405 Subpart O addresses determination and appeal procedures. Subpart S provides the basis for denying suppliers of services. The statutory authority is directly implied in sections 1832, 1861 and 1881 of the Act which authorize the Secretary to establish Conditions of Participation or Coverage.

B. Vacated Actions Which Are Not Denials.--If you are contacted by a potential provider and schedule a survey, but you cancel the survey after finding out that the party is either no longer interested in participating or in meeting program requirements, notify the RO by completing the HCFA-1539 and indicate the lack of interest. The RO will send a written notice to the potential provider to document the reason why the certification action was not completed. Despite the lack of interest, if the potential provider operates an ICF or SNF component, you still must prepare a section 1861(j)(1) certification, if indicated.

C. Vacated Actions Which Are Denials.--If a potential provider or supplier is surveyed and deficiencies are cited, forward the HCFA-1539 and related documentation to the RO, even when the Request for Participation is subsequently withdrawn. The RO will then either notify the provider or supplier of the failure to meet eligibility requirements or affirm the provider's or supplier's request to withdraw. Use the HCFA-1539 to transmit all certification forms and pertinent documents to the RO within 45 days of the survey. Include a section 1861(j)(1) certification, if indicated.

Do not prepare a crucial data extract if you were unable to complete a Survey Report.

3005. BASIS FOR TERMINATING PROVIDER PARTICIPATION--CITATIONS AND DISCUSSION

A. Medicare Provider Agreements.--Provider agreements and agreements with clinics as to the provision of outpatient physical therapy are terminated by the RO under the authority of section 1866(b) of the Act. 42 CFR 489.52-489.57 set forth the rules for terminating agreements. Medicare providers (as defined in §2002) must substantially meet each of the applicable Conditions of Participation.

B. Termination of Coverage of Supplier Services Subject to Certification.--Sections 1832(a), 1861(p) and (s), and 1881(b) of the Act authorize the Secretary to establish various Conditions for Coverage of supplier services, and thus impliedly authorize determinations that the Conditions cease to be met. Regulations (42 CFR 405.1502(b)) provide that the Secretary will make findings, setting forth pertinent facts and conclusions, and an initial determination as to whether a supplier meets the respective Conditions for Coverage. The determination can be made as a result of a written request by the supplier to start or expand services, or to establish that a supplier continues to meet respective Conditions for Coverage. An adverse determination may involve one or more areas of services offered by a supplier. Reimbursement for the services involved in the adverse determination ceases immediately. While these adverse determinations are not referred to in the regulations as "terminations," their effect on reimbursement for the supplier's services is the same as when a provider agreement is terminated. Procedures for certifying supplier noncompliance are parallel to those for certifying provider noncompliance.

The agreement which an ambulatory surgical center (ASC) or rural health clinic (RHC) enters into is a category specific agreement and not a provider agreement. It is the coverage of ASC or RHC services that is terminated, not the agreement.

C. Termination of Medicaid Participation.--The Medicaid agreement must be terminated by the State Medicaid agency when you determine that the provider does not meet applicable program requirements.

D. Cancellation of Medicaid Agreement by the Secretary.--HCFA has authority under section 1910(c)(2) of the Act to cancel the approval of a SNF or ICF to participate in the Medicaid program when HCFA determines that the facility fails to comply substantially with the Conditions of Participation, 42 CFR 405, Subpart K (SNFs), or with the standards contained in 42 CFR 442, Subparts D, E, F, or G (ICFs). In these instances the cancellation is prospective, usually occurring after the provider has had the opportunity for a formal hearing before an administrative law judge.

However, if there is an immediate and serious threat to patients' health and safety, cancellation occurs within 5 days after notification by the RO with opportunity for a post-termination hearing.

This authority is in addition to the authority under 42 CFR 442.30 which provides that a provider agreement is considered invalid for purposes of providing Federal financial participation (FFP) to the State, unless the State has followed proper procedures; for example, the State Medicaid agency issued the provider agreement even though the SA has not certified the facility as being in compliance. In those instances, the agreement is considered void from its inception, and the State is not entitled to FFP for any of the bills related to the facility.

E. Cause for Termination.--HCFA may terminate provider participation (Medicare providers only) if the provider is not complying substantially with the provisions of title XVIII and applicable regulations, or not complying with the provisions of its agreement (42 CFR 489.53). However, certain causes for termination are unrelated to certification and have no impact on the SA.

They are:

1. The provider places restrictions on the persons it will accept for treatment, and it fails either to exempt Medicare beneficiaries from those restrictions or to apply those restrictions to Medicare beneficiaries the same as to all other persons seeking care;

2. The provider fails to furnish information necessary for HCFA to determine whether or not payments are, or were, due under Medicare and the amount due;

3. The provider refuses to permit examination of its fiscal or other records by, or on behalf of, HCFA as necessary for verification of information furnished as a basis for payment under Medicare;

4. The provider has knowingly and willfully made or caused to be made any false statement or representation of a material fact for use in a request for payment under Medicare;

5. The provider has submitted, or caused to be submitted, requests for payment under Medicare or amounts for items and services substantially in excess of the costs incurred by providing the items and services;

6. The provider has furnished items or services which HCFA determines to be substantially in excess of the needs of individuals or of a quality that fails to meet professionally recognized standards of health care;

7. The provider fails to furnish information on business transactions as required;

8. The provider fails to disclose information on convicted principals;

9. The provider fails to furnish ownership information; or

10. The provider fails to comply with civil rights requirements.

Your responsibility is to certify provider compliance with program requirements. Fiscal intermediaries generally are responsible for dealing with those matters related to reimbursement and coverage. However, in the course of a survey, a surveyor may encounter information which may be indicative of program abuse or failure to meet other program requirements described in the list above. Communicate these areas of concern to the RO for further action.

F. Termination of Title XIX-Only Skilled Nursing and Intermediate Care Facilites.--Federal Medicaid regulations provide for terminations, nonrenewals, and cancellations, but do not fully describe the implementing procedures. Each State has developed procedures for terminating agreements with SNFs and ICFs when those facilities are not found to be in substantial compliance with program requirements. In any Medicaid-only noncompliance situation, initiate the action, prepare the necessary documents, and forward the documentation to the State Medicaid agency, which has the responsibility for the termination, nonrenewal or cancellation of the Medicaid agreement. In this case, the State Medicaid agency must notify HCFA and the public of its action, and must afford the facility notice and opportunity for a hearing.

Under 42 CFR 431.54(f), the State Medicaid agency may also "lock out" a title XIX participating SNF or ICF for a reasonable period of time if the facility has abused the Medicaid program. This may occur even though the SA has approved the facility. There are no certification instructions directing the SA to participate in "lock out" procedures.

G. Termination Action Based on Onsite Federal Survey.--When immediate and serious threat to patient health and safety is found by a RO survey team whether in the course of a regular scheduled Federal monitoring survey or in response to a complaint, or as part of the JCAH validation effort, the RO initiates termination procedures. Survey findings and factual development are the responsibility of the RO, although you may be asked to assist in documenting or developing aspects of the termination. You, (and the State Medicaid agency, if the provider/supplier also participates in Medicaid,) are notified by the RO of the action being taken.

3008. PROVIDER/SUPPLIER GIVES NOTIFICATION OF VOLUNTARY TERMINATION (MEDICARE)

A provider or supplier may voluntarily terminate its participation in the Medicare program by notifying HCFA of its intent in writing. If you learn that a provider intends to close its business or wishes to voluntarily terminate:

1. Advise the provider to write a letter to the RO notifying it of the intent and the requested date of withdrawal or closure; and
2. Submit a HCFA-1539 and any related documentation to the RO.

After receiving notice, the RO will communicate with the provider regarding notification to the public, etc.

The State Medicaid agency notifies the SA and the RO whenever a Medicaid-only SNF or ICF voluntarily terminates its agreement with the State Medicaid agency.

If a voluntary termination is intended to avoid termination for cause, information to that effect should be documented by the SA and RO, retained in the certification file, and considered if the provider requests participation in the future.

3009. PROVIDER/SUPPLIER GIVES NO NOTIFICATION OF GOING OUT OF BUSINESS (MEDICARE)

If a Medicare provider/supplier ceases all business operations, discharges all patients, and refuses new admissions the provider/supplier is considered as voluntarily terminating its agreement or its coverage.

If you learn that a provider/supplier may be going out of business, contact the provider/supplier to verify the situation. Notify the RO immediately to arrange for the public notice which will be published by the RO. The RO sends notice of termination to the provider with copies to the SA, the servicing Social Security office, and the Part A intermediary. The RO sends notice of a supplier going out of business or cessation of Medicare coverage to the supplier, with copies to the SA, the State Medicaid agency, and to those Part B carriers likely to be concerned. Notify the RO immediately if you learn that a provider/supplier has already closed.

3010. TERMINATION PROCEDURES--IMMEDIATE AND SERIOUS THREAT TO PATIENT HEALTH AND SAFETY (MEDICARE)

A. Substantial Noncompliance With Program Requirements Which Pose an Immediate and Serious Threat to Patient Health or Safety.--"Immediate and serious threat" is interpreted as a crisis situation in which the health and safety of patients is at risk. Generally, it is a deficient practice which indicates the operator's inability to furnish safe care and services. An immediate and serious threat to patient health or safety may exist in the presence of one or more of the following (or similar) situations. This list is not to be interpreted as all inclusive, but rather as examples of what HCFA believes may constitute an immediate and serious threat. The surveyor is always expected to describe findings in sufficient detail to show the relative seriousness of the hazard.

1. Situations or practices that constitute a serious fire hazard or emergency situation such as:

a. Inadequate or faulty emergency power and lighting in the operating, recovery, intensive care, or emergency rooms;

b. Bare electrical wiring that presents an immediate fire hazard;

c. Blocked or obstructed stairways, hallways and exits which prevent egress in the event of an emergency;

d. Widespread failure to enforce smoking restrictions;

e. Failure to maintain required fire protection systems (fire alarm, sprinkler systems) in an operating condition; or

f. Failure to maintain the integrity of fire and smoke barriers, such as removal of stairway doors and major unprotected openings in corridor walls.

2. Widespread insect or rodent infestation indicative of food contamination or the possible spread of contagion.

3. Failure to control infections as evidenced by the presence of facility acquired infections.

4. Widespread patterns of patient abuse or poor patient care, including:

a. Instances of malnutrition or dehydration that are unrelated to the patient's condition and are a result of poor patient care;

b. A pattern of negligence by staff with the result that patients are often left lying in urine, feces or other waste;

c. Use of physical or chemical restraints, that are in excess of that which is ordered by a physician.

5. Drug or pharmaceutical hazards that directly affect patient health and safety, such as:

a. Widespread drug errors, mishandling of drugs or other patient related pharmacy problems;

b. Failure to provide medications as prescribed;

c. Failure to monitor drugs as evidenced by lack of ordered laboratory work, failure to take vital signs as indicated by drug regimen, and lack of other nursing monitoring practices;

d. Gross mishandling of drugs such as leaving drug trays unattended and available to patients and visitors.

e. Administration of drugs by unqualified staff; or

f. Administration of experimental drugs without the informed consent of the patient (or responsible party).

6. Inadequate procedures for procurement, safekeeping and transfusion of blood and blood products that could jeopardize patient health and safety.

7. Excessive hot or cold temperatures in patient care areas of facility to the extent that patients are experiencing signs of hyper or hypothermia and the provider/supplier does not have a short term and effective plan for ameliorating these temperatures.

8. A pattern of delivering services to patients when the daily care needs of the patients exceed the provider's/supplier's capacity to give care. For example, accepting patients requiring total parenteral nutrition through subclavian catheters when the provider lacks policies and procedures for this specialized care, nursing staff are not knowledgeable about the technology, and essential equipment is not available.

B. Processing of Immediate and Serious Threat Terminations.--When an immediate and serious threat to patient health or safety is documented, complete all termination procedures within 23 calendar days. Processing times given here are the maximum time allowed. Do not postpone or stop the procedure unless compliance is achieved and documented through onsite verification. If there is a credible allegation that the threat or deficiency has been corrected, at least one resurvey prior to termination must be conducted. Do not use this procedure if there is a time-limited provider agreement that is subject to cancellation or nonrenewal within 23 days after the survey. In such a case, process the cancellation or nonrenewal as explained in §3020.

1. Date of Survey.--The date of the survey is the date on which the entire survey is completed (i.e. the date of the exit conference).

2. Second Working Day.--No later than 2 working days following the survey date:

a. Telephone the RO that you are certifying non-compliance and that an immediate and serious threat exists; and

b. Notify the provider/supplier (by overnight express mail) of its deficiencies, that you are recommending termination to the RO, and that the RO will issue a formal notice (Exhibit 40). The notice will advise the provider/supplier of rights to due process, the time schedule for the termination action, and that the deficiency must be corrected and the correction verified by you, to halt the termination process. If the provider also participates in Medicaid, notify the State Medicaid agency of your certification.

In the case of a clinical laboratory supplier where non-compliance with a Condition for Coverage is found, send notification to the RO within 2 working days following the survey.

3. Third Working Day.--Forward all supporting documentation to the RO.

4. Fifth Working Day.--The provider/supplier and public will be notified by the RO of the proposed termination action by the most expeditious means available.

(The next page is 3-7)

5. Tenth Working Day.--Send completed HCFA-2567 to the RO.

6. Twenty-Third Calendar Day.--The termination takes effect. These dates are maximum times and participation should be terminated earlier if processing allows.

Medicaid agreements with facilities that concurrently participate in Medicare must be terminated on the same date the Medicare agreement is terminated (42 CFR 442.20). Where State law permits, Medicaid-only facilities should be terminated by the State within the above time limits.

3012. TERMINATION PROCEDURES--NONCOMPLIANCE WITH ONE OR MORE CONDITIONS OF PARTICIPATION OR COVERAGE AND CITED DEFICIENCIES LIMIT CAPACITY OF PROVIDER/SUPPLIER TO FURNISH ADEQUATE LEVEL OR QUALITY OF CARE (MEDICARE)

Failure to substantially meet one or more Conditions is one cause for termination of program participation. "Substantially", for purposes of this section, is defined as meeting the intent of applicable Conditions of Participation or Coverage. Any provider/supplier that does not substantially meet all Conditions shall be considered to be limited in its capacity to furnish services of an adequate level or quality. Compliance can never be certified based upon a plan of correction or acceptable progress since the law specifically requires that all Conditions of Participation or Coverage must be met. If there is not an immediate and serious threat to patient health or safety, use the following procedural schedule:

Exception: Do not use this procedure if there is a time-limited agreement that is subject to cancellation or nonrenewal within 90 days after the survey. In such a case process the cancellation or nonrenewal as explained in §3020.

1. Date of Survey.--The date of the survey is the date on which the entire survey is completed (i.e. the date of the exit conference).

2. Fifteenth Day.--Notify the provider/supplier of cited deficiencies. Inform the provider in writing that the failure to achieve compliance within 45 calendar days after the survey will result in your recommendation that termination action be initiated. Alert the RO by telephone that you are considering an unfavorable certification.

3. Forty-Fifth Day.--If the provider promised through a reasonable plan to achieve compliance (§3030), conduct a one time revisit to determine whether or not compliance or acceptable progress has been achieved.

4. Fifty-Fifth Day.--If compliance has not been achieved, certify noncompliance and forward the certification and supporting documentation to the RO. Notify the provider/supplier that termination is being recommended (Exhibit 40). Alert the State Medicaid agency if the provider/supplier is participating concurrently in the Medicaid program.

5. Seventieth Day.--The RO will send an official termination notice to the provider/supplier. The RO will send a copy to the State Medicaid agency if the provider/supplier also participates in the Medicaid program.

6. Ninetieth Day.--Termination takes effect if compliance has not been achieved. It can take effect in less that 90 calendar days if all required procedures have been completed.

3014. INTERRUPTION OF TERMINATION TIMETABLE

A. Credible Allegation of Compliance.--Conduct a revisit following a credible allegation of compliance by a provider/supplier. Notify the RO of the date of the forthcoming revisit. A credible allegation is one:

1. Made by a provider/supplier with a history of having maintained a commitment to compliance, taking corrective action if required, and

2. That is realistic in terms of the possibility of the corrective action having been accomplished between the exit conference and the date of the allegation, and

3. That actually resolves the problems created by the deficiency.

Only restoration of compliance can rescind termination action.

B. Informal Hearings Do Not Interrupt the Timetable.--The process may not be postponed to accommodate informal hearings or meetings or to give the provider additional time to achieve compliance. Such discussion may, however, be conducted within the procedural time limits in §3012, as deemed appropriate by the RO. This 90 day procedure provides adequate time for the provider to achieve compliance if the decision by the RO is to wait the full time allowed and if the well-being of patients is not jeopardized in the interim.

C. Acceleration of Timetable.--Switch from the 90-day procedures of §3012 to the accelerated procedures of §3010 at any point when:

1. There is an immediate threat to patient health and safety, or

2 An acceptable and reasonable plan of correction is not submitted; i.e., the provider cannot achieve compliance within 90 days, or,

3. The provider has not shown good faith efforts to achieve and maintain compliance with all program requirements.

D. Termination Development Coinciding with Change of Ownership Development.--A change of ownership does not affect completion of a termination action. Do not postpone any required termination. Do not solicit a plan of correction from the new owner. Court appointed receivership is not a basis for cessation of the termination process. Following termination, the new owner may, however, request approval for participation as a new provider, subject to reasonable assurance provisions. (See §2016.)

E. Disagreement Over Deficiencies.--A provider that disagrees with any SA finding regarding a cited deficiency or an acceptable plan of correction should be advised to annotate its position on the plan of correction in statutory or regulatory terms, and should specify why the SA's citation is not correct. This information does not interrupt the termination process, but is publicly disclosable and will be included in the documentation considered during subsequent reconsideration and hearings.

3016. TERMINATION - DOCUMENTATION REQUIREMENTS

A. Documentation to Support Proposed Termination.--All documents to support a proposed termination must be complete, accurate, and logical in sequence. Each document must be dated and signed by the preparer or indicate the date of receipt in the SA. The documentation must be supported by a complete current Survey Report.

1. Current Survey Report.--Review the current Survey Report to ensure that all items are properly completed. If there are any changes or erasures, initial the item and explain the basis for the modification in the explanatory remarks column.

Include the following information in th explanatory remarks column for each item checked "not met:"

a. A description of the deficiency;

b. Whether the deficiency existed during the previous survey and whether or not compliance was achieved;

c. Current plans for correction, if any; and

d. An estimate of whether or not there is a prospect of compliance with all eligibility requirements within the time limits and the basis for this opinion.

2. Previous Survey Reports.--Review previous Survey Reports for consistency. If a deficiency is reported on the current Survey Report that has obviously existed for some time, explain why it was not reported previously; e.g., serious structural defects, inadequate fire escapes.

Explain any conclusions that might be questioned, especially if certain requirements are being weighed heavily. Examples would include:

a. The majority of standards are checked "not met," yet the Condition is found in compliance; or

b. A Condition is found not in compliance based upon the relationship of standards or factors (non-statutory) not being met.

B. Record of Contacts with Providers/Suppliers.--Include in documentation, copies of communications and written reports of oral communications with providers/suppliers including the date of contact, the person involved, the purpose, and the content of the communication. Include reports of any consultation which describe the nature of the consultation and the provider's/supplier's response to the advice or services offered. If consultation was requested but not furnished, explain why it was not furnished. Also include reports of investigations of complaints.

C. Notification to Provider/Supplier of Deficiencies and Recommendation of Termination.--Include in the file a copy of the letter notifying the provider/supplier of the deficiencies found on the survey and advising them that failure to correct would result in a recommendation for termination. Also include copies of any other SA notices to the provider/supplier.

3020. NONRENEWAL OR CANCELLATION OF TIME LIMITED AGREEMENTS FOR LONG TERM CARE FACILITIES (MEDICARE AND MEDICAID)

A. General.--Time limited agreements (TLAs) of 12 months or less are required by regulations for SNFs, ICFs and ICFs/MR. Like any agreement, a TLA may be terminated. However, unlike other agreements, a TLA may also be nonrenewed or automatically cancelled. The decision to terminate instead of nonrenew or cancel depends on the timing of the onsite survey; i.e., how close in time the survey is to the expiration date or automatic cancellation date, and the seriousness of the deficiencies cited.

Nonrenewal and cancellation are preferred alternatives to termination if termination would be effective after the time of projected renewal or automatic cancellation date.

B. Nonrenewal of Time Limited Agreements.--A nonrenewal is the decision not to renew a TLA following its expiration.

1. Situations Leading to Nonrenewal.--A facility does not qualify for renewal of its agreement if it has been determined, based on resurvey, that:

a. The provider has violated the terms of its agreement or the provisions of title XVIII or title XIX, or applicable regulations; or,

b. The provider does not substantially meet one or more program requirements (e.g., Conditions of Participation for SNFs and standards for ICFs or ICFs/MR, or has an unacceptable plan of correction); or

c. The provider continues to be substantively out of compliance with the same standard(s) (consistently maintains major deficiency) for SNFs, ICFs, or ICFs/MR that were found out of compliance during the last survey on which the current certification period was based.

EXCEPTION: A new period of certification may be approved even though the same standard(s) was out of compliance at the time of resurvey if the deficiencies did not substantially limit the facility's ability to furnish adequate care or adversely affect the health and safety of patients and the facility can document that it achieved compliance during the term of the agreement, but for reasons beyond its control was again out of compliance prior to the expiration of the agreement.

2. Timing of Resurvey.--In nonrenewal cases, the facility must be given formal notice of the RO's decision not to enter into a new agreement a full 30 days prior to the date of expiration of its existing agreement. Therefore, complete the recertification survey between 60 and 120 days in advance of the expiration of the term of the agreement. All nonrenewal procedures must be completed by the expiration date of the current agreement.

Process a termination in lieu of nonrenewal if the renewal date is more than:

a. 90 days after finding noncompliance, or

b. 23 days if you find there is an immediate and serious threat to patient health and safety (Medicare).

3. Facility Does Not Want to Renew.--A participating facility may choose not to renew its agreement. In such cases, it is assumed that the facility's intentions will have been made known in time to permit public notice before the end of the existing agreement. However, there may be cases where a facility will give insufficient notice of its intention not to accept renewal. In these cases the agreement may have to be extended to prevent hardship to the program beneficiaries being furnished care by the facility.

C. Cancellation of Time Limited Agreements for Long Term Care Facilities.--

1. General.--The time limited agreement may contain an automatic cancellation clause. In this case, you specify a date that is not later than the 60th day following the end of the time period specified for such corrections, and is not later than the end of the ninth month of the agreement. The cancellation clause provides that if the corrections of deficiencies are not made by the date you have specified, or if substantial progress has not been achieved in accordance with an accepted plan of correction, the agreement will automatically terminate on that date. However, if substantial progress is made and an updated plan of correction accepted, the facility may continue to participate. Establish a control on all cancellation clause agreements to ensure that you schedule a verification visit to be performed as soon as possible after the last date specified in the facility's plan of correction. Allow processing time in advance of the cancellation date.

The procedures implementing the cancellation clause are similar to those required for an involuntary termination and as such require comparable development, supporting documentation, and internal clearance action.

However, the basis for invoking this clause may be limited to establishing that the facility has not made substantial progress in carrying out its plan of correction. Whenever a cancellation clause is "invoked" (the 30-day notice is sent) termination action will be taken to remove the facility from participation status. All cancellation procedures must be completed by the cancellation date.

Document and notify the RO (State Medicaid agency for Medicaid facilities) if the verification visit establishes that the facility has made the necessary corrections, or has made significant improvement, justifying continuance of the agreement based on an updated plan of correction. To document correction or significant improvement, use one or both of the following forms:

a. HCFA-2567B for deficiencies which have been corrected. Complete in accordance with §2732B.

b. Revised HCFA-2567 for deficiencies not corrected. Complete in accordance with §2732B. Prepare and forward the documentation with a HCFA-1539, noting your recommendation.

The RO notifies the Medicare participating provider that based on the correction of all deficiencies or the revised plan of correction, the cancellation clause will not be invoked and the agreement will continue to its full term. A similar notice is sent by the State Medicaid agency regarding Medicaid participation.

2. Substantial Progress in Correcting Deficiencies Where There is a Cancellation Clause.--"Substantial progress" means that corrections are well underway; that there is tangible and visible progress. For example, if the installation of a sprinkler system is required but the system is not yet operating, there should be evidence of progress at the time of the revisit, such as the installation of piping. If the only progress by the facility to date has been a loan application which is still pending, this would not constitute substantial progress sufficient to prevent invoking the cancellation clause. However, document extenuating circumstances that are beyond the control of the facility as they can be considered in determining whether or not to continue the facility in the program.

If the verification visit establishes that the facility has made the necessary corrections, or has made significant improvement justifying continuance of the agreement based on an updated plan of correction, complete the following forms:

a. HCFA-2567B for deficiencies which have been corrected. Complete in accordance with §2732B.

b. HCFA-2567--Include deficiencies not corrected from the previous HCFA-2567, in accordance with §2732B.

3. Facility Fails to Make Corrections or Substantial Progress.--Documentation for invoking the cancellation clause need not necessarily be as extensive as that for an involuntary termination. However, while survey efforts may be limited to the confirmation of the continued existence of the deficiencies, the documentation must be clear, convincing, and of the same high quality as that for an involuntary termination action.

When a cancellation clause is invoked, process a HCFA-1539 to recommend termination of the agreement with the provider.

3025. NOTICE OF TERMINATION (MEDICARE)

The RO notifies the provider/supplier of its termination by letter at least 15 days before the effective date of the termination. The RO mails a copy of the letter to the SA and to the State Medicaid agency, if appropriate. The notification contains information regarding the provider's/supplier's right to appeal the termination. The RO concurrently notifies the public giving the reason for and the effective date of the termination.

3030. ADDITIONAL COMMUNICATIONS WITH PROVIDERS/SUPPLIERS

After you forward the certification of noncompliance, clear any further communications to the provider/supplier with the RO. Unrecorded visits, surveys, or correctional allegations that were not reported before final termination action could cause embarrassment or even result in failure to sustain the termination action. Even after final termination action, any additional contacts may be pertinent to proper handling of the case. Notify the RO of any such contacts.

3035. PROVIDER UNDERGOES CHANGE OF OWNERSHIP DURING TERMINATION PROCEEDINGS

If you learn that the provider is initiating a change of ownership, do not interrupt completion of your documentation of the certification of noncompliance. Continue to document the noncompliance of the previous owner. Do not send a HCFA-1539 for the purpose of reporting the change.

Notify the RO by telephone of information known about a change of ownership.

3040. RECONSIDERATION PROCEDURES (MEDICARE)

A. Right to Reconsideration of an Initial Denial or Non-Renewal.--Reconsideration is granted administratively, not statutorily, pursuant to regulations 42 CFR 405.1510-405.1518. Any provider that is dissatisfied with an initial determination that it does not qualify as a Medicare provider may submit a request within 60 days that the Secretary reconsider the decision.

Reconsideration is a review of the determination. This review results in affirmation or reversal of the determination. Further appeal rights include hearing before an Administrative Law Judge and review by the Appeals Council.

B. Request for Reconsideration.--A request for reconsideration is any written expression of dissatisfaction with the initial decision. The request may be in the form of a letter, statement, or submittal of a new Request to Establish Eligibility and may be signed by any responsible official of the provider or by an attorney on behalf of the provider. Officially date or date-stamp any request the day of receipt in the SA.

C. Acknowledgement of Reconsideration Request.--Acknowledge the request promptly. Forward a copy of the request and acknowledgement letter immediately to the RO. The RO will advise if additional development is required. Also, forward any subsequent information received that would affect the reconsideration or hearing. If the request is filed by an attorney, send a copy of the acknowledgement to the provider. Most cases will require redevelopment by the SA, particularly if there are questions about the provider's efforts and plans to correct previously cited deficiencies. If requesting additional evidence, stipulate in the acknowledgement a reasonable deadline for submittal.

D. Documentation of the File.--A reconsideration review (following denial or nonrenewal) is not complete unless the file contains adequate documentation to fully explain every statutory deficiency and finding of non-compliance with program requirements. Send to the RO all reports of onsite visits and telephone contacts with the provider as well as any pertinent information available from the licensing agency.

E. Adverse Action Progress.--As the reconsideration develops, you may receive requests for information and status reports from the RO.

4. An opportunity for the facility or its representatives to be heard in person, to call witnesses, and to present documentary evidence;

5. An opportunity for the facility to cross-examine witnesses; and

6. A written decision by an impartial decision maker, setting forth the reasons for the decision and the evidence upon which the decision is based.

C. Judicial Review.--Federal regulations do not provide for judicial review of these appeals proceedings. Judicial review is governed by State law.

D. Impartial Decision Maker (Hearing Officer).--States have flexibility in selecting individuals to conduct the reconsideration and hearing proceedings. However, in both proceedings, certain individuals should be excluded from serving as decision makers.

In reconsideration proceedings, the surveyors, as well as other persons directly involved in gathering and providing evidence upon which the adverse action is based, are ineligible to make the decisions. (One person should not be both witness and judge.) However, the person who made the original determination based on the surveyors' findings is not ineligible to decide the reconsideration. If the decision is originally made at the highest level the appeal decision should also be made there. However, if the original decision is made by a regional supervisor, someone higher in authority should review the appeal.

In administrative hearings all persons directly involved in either the survey or the reconsideration process are ineligible for reasons of impartiality.

3050. CLINICAL LABORATORY IMPROVEMENT ACT (CLIA) ADVERSE ACTIONS

There are two types of CLIA adverse actions:

1. Those resulting from unsatisfactory performance in CDC's Proficiency Testing (PT) program; and,

2. Those which occur as a result of an onsite laboratory survey.

[COMMITTEE STAFF NOTE: This document was distributed to State surveyors during training for the new long term care survey process, conducted by HCFA central office in the Winter of 1986.]

✓ Kent/Sharon Harris

INSPECTION AND ENFORCEMENT VERSUS CONSULTATION

NOT FOR
ICF
ONLY
MUST BE
SNF or
SNF/ICF

The primary role of the surveyor is to assess the quality of care provided by a health care facility. In performing Medicare/Medicaid survey activities, the surveyor is charged with ensuring that the facility is in compliance with all the conditions of participation as set forth in the Federal Code of Federal Regulations. The surveyor's responsibility is to advise the facility management of deficiencies identified during the course of the survey and to ensure that appropriate action is taken to correct the deficiencies. As such, the survey process is properly characterized as an inspection and enforcement process.

Some questions have recently been posed as to the survey process also including a surveyor consultation function. Among the surveyor's responsibilities both during and after the onsite visit is to identify the deficiencies in accordance with specific regulatory requirements in an effort to assist the provider or supplier in complying with deficient conditions. This identification and communication of the deficiency to the provider or supplier is referred to as "consultation" in the regulations (42 FR 405.1903(a)). However, this type of consultation does not include professional technical advice on how a specific deficiency might be corrected. It is HCFA's policy that facility operators who are in business to provide a certain type of health care, should be fully qualified to independently manage and operate their institutions in accordance with good business practice. If a facility needs the services of a professional consultant to advise them on business or health related matters, then they should undertake to hire one. Surveyors should not provide such consultation since budget allocations to the States for surveyor staffing resources do not include funding for consultative services. Also, the surveyor's role as inspector and enforcer may be compromised if the surveyor approves plans of correction that accommodate only the surveyor's suggested remedial action and do not necessarily address the real problem. While the facility operator might find it easier to simply adopt the surveyor's suggestions, there is no assurance that the surveyor has found the real root cause of the deficiency. For example, if a surveyor in a nursing home learns that residents are being served cold meals, it is not the surveyor's responsibility to determine the root cause (e.g., lack of aide training in food service, meals not properly cooked, food warmers broken, etc.). Rather, the surveyor should simply indicate that food is being served cold. The facility management should determine what caused the problem and submit a plan of correction to address it. The surveyor, on returning to the facility for a followup, should not look to see if the facility has taken the action indicated on the plan of correction, but should rather make a determination based on interview and observation that the food, in fact, is now being served at the proper temperature.

Finally, while surveyors should never function as consultants, and should not delve into the facility's policies and procedures to determine the root cause of a deficiency, surveyors should point out an obvious problem that has surfaced either during the survey itself or at the exit conference. For example, a surveyor should point out that he or she noticed that the temperature control on a food warmer device was set at an improper level.

HCFA,HSQB, Office of Survey and Certification

January 1986

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

6325 Security Boulevard
Baltimore, MD 21207

JAN 16 1986

John J. Jarrell
President, Association of Health Facility
  Licensure and Certification Directors
Director, Health Facilities Evaluation Division
West Virginia Department of Health
1800 Washington Street, East
P & G Building
Charleston, West Virginia 25305

Dear Mr. Jarrell:

The Office of Survey and Certification, in the Health Standards and Quality Bureau, would like to assemble a group of representatives from industry, professional, State, and consumer organizations. This group would meet on a periodic basis every three to six months to discuss issues of common concern. Another purpose would be for us to seek your assistance on survey and certification related proposals during the early developmental phase to improve program decision-making. Participation in this effort would enable you to voice your support or opposition, orally and in writing, to various proposals that directly or indirectly affect your constituency. You would also have the opportunity to offer your own proposals for the group's consideration.

We would like to schedule meetings throughout the coming year, beginning in March in the Baltimore-Washington area. The location would depend on the number of participants that wish to attend each meeting and the availability of meeting space. An agenda would be prepared describing the topics for each meeting and specific proposals, if proposals have been developed.

If you are interested in participating, we will send you an agenda for the first meeting in about 4 to 6 weeks. Once you have had the opportunity to review the agenda, we would like you to indicate which of the meetings you plan to attend. Also, we would welcome your suggestions of topics for future meetings.

We appreciate that some of the topics will be of minimal interest to your organization and that other responsibilities will preclude your attendance at some of the meetings. You should plan to attend only those sessions of interest to you or your organization. However, to ensure representative viewpoints are presented for consideration, we must limit participation to one representative from each group or organization.

Page 2

If you are interested in participating, please complete and return the enclosed form. Specifics, concerning times and locations for each of the meetings, will be sent to you approximately one month before each meeting. Further questions can be directed to Theresa Spady of my staff. Theresa can be reached on area code 301-597-5132. The mailing address is:

The Health Care Financing Administration
Health Standards and Quality Bureau
Office of Survey and Certification
2-D-2 Meadows East Building
6325 Security Boulevard
Baltimore, Maryland 21207

I look forward to your participation in this forum. A list of other organizations being invited is enclosed for your information.

Sincerely yours,

Sharon Harris

Sharon Harris
Acting Director
Office of Survey and Certification

Addressee List

Survey and Certification Forums

Carol Fraser Fisk, Acting Commissioner
Administration on Aging
Room 4760
HHS Building
330 Independence Avenue, S.W.
Washington, D.C. 20201

Helen K. Kerschner, Executive Director
American Association of Homes for the Aging
1050 17th Street, N.W.
Suite 770
Washington, D.C. 20036

Meredith Cole
American Association of Retired Persons
1909 K Street, N.W.
Washington, D.C. 20049

Kathleen M. Griffin, Ph.D.
Executive Vice-President
American College of Health Care Administrators
8120 Woodmont Avenue
Suite 200
Bethesda, Maryland 20814

Julian Haynes, Ph.D., Executive Director
American Dietetic Association
430 North Michigan Avenue
Chicago, Illinois 60611

Morrie Levy, Executive Director
American Federation of Home Health Agencies
429 N Street, S.W.
Suite S-605
Washington, D.C. 20024

Paul Willging
Executive Vice President
American Health Care Association
1200 15th Street
Washington, D.C. 20005

James Marrinan, Director
Division of Federal Agency Liaison
American Hospital Association
444 N. Capital St., N.W.
Washington, D.C. 20001

Addressee List

Survey and Certification Forums
(Continued)

Martin Houchbaum
American Jewish Congress
15 East 84th Street
New York, New York 10028

Patricia A. McGuire, Assistant Director
Department of Federal Affairs
American Medical Association
1101 Vermont Avenue, N.W.
Washington, D.C. 20005

Susan Miller
American Medical Records Association
875 Michigan Avenue
Chicago, Illinois 60611

Pamela Mittlestadt, R.N., MPH
Government Relations Division
American Nurses Association
Suite 200
1101 143 St, N.W.
Washington, D.C. 20005

James J. Garibaldi
Executive Director
American Occupational Therapists Association
1383 Picard Drive, Suite 300
Rockville, MD 20850

John Perrin
Executive Director
American Osteopathic Association
212 East Ohio Street
Chicago. Illinois 60611

Charlie Harker, Director
Government Affairs
American Physical Therapy Association
1111 N. Fairfax St.
Alexandria, Virginia 22314

American Podiatry Association
20 Chevy Chase Circle, N.W.
Washington, D.C. 20015

William McBeath
Executive Director
American Public Health Association
1015 15th Street, N.W.
Washington, D.C. 20005

Addressee List

Survey and Certification Forums
(Continued)

Tim Webster
Executive Director
American Society of Consultant Pharmacists
2300 Ninth Street South
Arlington, Virginia 22204

Lynn Podell, J.D.
Director
American Society for Medical Technologists
1725 DeSales Street, N.W.
Suite 403
Washington, D.C. 20036

John J. Jarrell
President, Association of Health Facility
Licensure and Certification Directors
Director, Health Facilities Evaluation Division
West Virginia Department of Health
1800 Washington Street, East
P & G Building
Charleston, West Virginia 25305

Judy Brown
Beverly Enterprises, Inc.
873 South Fair Oaks Avenue
P.O. Box 90130
Pasadena, California 91109-5130

George Degnon, Executive Director
Association of State and Territorial Health Officials
1311 A Dolly Madison Boulevard
Suite 3A
McLean, Virginia 22101

Frances Ryan, Assistant Director
Inspection and Accreditation Program
College of American Pathologists
7400 N. Skokie Blvd.
Skokie, Illinois 60077

Ann Hunter, Ph.D.
Consultant Dietitians in Health Care Facilities
8235 Stoneridge
Wichita, Kansas 67206

Neil Elliot, President
Hillhaven, Inc.
The Hillhaven Corporation
1148 Broadway Plaza
Tacoma, Washington 98401-2264

Addressee List

Survey and Certification Forums (Continued)

Johns Hopkins School of Hygiene and Public Health
615 N. Wolfe St.
Baltimore, Maryland 21205

Hospital Corporation of America
2000 L Street, N.W.
Washington, D.C. 20049

Paul Mullen
Department of Government Relations
Joint Commission on Accreditation of Hospitals (JCAH)
875 N. Michigan Avenue
Suite 2000
Chicago, Illinois 60611

Mary Ann Keenan
Senior Staff Associate
National Association of Social Workers, Inc.
7981 Eastern Avenue
Silver Spring, Maryland 20910

Elma L. Griesel
Executive Director
National Citizens' Coalition
for Nursing Home Reform
1825 Connecticut Ave, N.W.
Washington, D.C. 20009

National Gray Panthers
806 15th Street, N.W.
Suite 432
Washington, D.C. 20005

Frances Humphrey
The Gray Panthers of Metropolitan
Washington
2480 16th St. N.W.
Washington, D.C. 20009

Pamela Maraldo, Ph.D., R.N.
Director
National League for Nursing
10 Columbus Circle
New York, New York 10019

Addressee List

Survey and Certification Forums
(Continued)

Clifford Whitman, Chairman
Long Term Care Committee
National Association of Areas Agencies on Aging
600 Maryland Avenue, S.W.
West Wing 208
Washington, D.C. 20024

National Association of Developmental
Disabilities Councils
1234 Massachusetts Avenue, N.W.
Suite 203
Washington, D.C. 20005

William Hutton
Executive Director
National Council of Senior Citizens
925 15th Street, N.W.
Washington, D.C. 20005

Anthony O'Neill, Vice President
National Fire Protection Association
Battery March Park
Quincy, Massachusetts 02269

National Health Law Center Program
Suite 304
1424 16th Street, N.W.
Washington, D.C. 20036

Tobey Edelman
National Senior Citizens' Law Center
2025 M Street
Suite 400
Washington, D.C. 20036

Association of Health Facility Licensure and Certification Directors

January 28, 1986

Ms. Sharon Harris, Acting Director
Office of Survey and Certification
Department of Health & Human Services
Health Care Financing Administration
6325 Security Boulevard
Baltimore, Maryland 21207

Dear Ms. Harris:

Thank you for your letter of January 16, 1986 in which you invited the participation of AHFLCD in discussions on survey and certification and related proposals and issues.

Please know that this Association is very interested in participating in such discussions, and I am looking forward to receiving an agenda for the first meeting. I am hopeful of notification with as much lead time as possible since the AHFLCD representative may be required to have an out-of-state travel request processed within his or her jurisdiction prior to the meeting.

Attached is the information requested in your letter with the exception of Part III (Additional Topics), which will be forwarded to you as soon as it is developed as fully as possible.

Sincerely,

John J. Jarrell, President
AHFLCD

JJJ/ej

cc: AHFLCD Board Members

monitoring the health care of a nation

Health Care Financing Administration
Survey and Certification Issues Forum

This form is designed to solicit your representation in a group that would periodically meet to discuss survey and certification issues. The first of such meetings would be held in early Spring 1986.

Please complete the following items to assist us in planning this first meeting.

Name of organization: Association of Health Facility Licensure & Certification Directors

Please check meeting location preference:
_____ D.C. Area
_____ Baltimore Area
_x_ No Preference

Participant Interest

Please complete Part 1 of this form to indicate your interest for each of the Topics listed. More detailed information will be sent to you well in advance of the meeting date.

Part 1

	Interested?		
	Yes	No	Topic
1.	✓		Effective Date - Determine to what extent a facility must be operational to be inspected and determined technically eligible to provide Medicare/Medicaid services.
2.	✓		Flexible Surveys - Consider whether and how Medicare/Medicaid regulations should provide for less than annual inspections based on facility type or compliance history.
3.	✓		Repeat Offenders - Decide if and how special termination provisions might apply to Medicare/Medicaid facilities with habitual compliance problems.
4.	✓		SAEP/CER - Review and consider revision of criteria for evaluating performance of "State survey agencies" (those agencies responsible under HCFA contract, for compliance inspections of Medicare/Medicaid facilities).
5.	✓		Complaints - Review and comment on proposals for a uniform process for investigation and action on complaints against Medicare/Medicaid facilities.
6.	✓		Immediate and Serious Threat or Immediate Jeopardy - Consider proposed criteria for determining when an immediate and serious threat to patient health and safety (a situation so severe as to require immediate evacuation/relocation of residents) exists in a long-term care facility.
7.	✓		Long Term Care Survey Process - Provide input into the design of a computer software package for interactive training of Medicare/Medicaid facility inspectors. This will specifically relate to the Patient Care and Services (PaCS) survey tool - a resident-oriented approach that emphasizes interviews and observation of facility residents.
8.	✓		Federal Monitoring Surveys (FMS) - Review the purpose and focus of FMS and discuss its future role in monitoring State survey agency performance.

9.	✓		Chain Organizations - Discuss the deficiency trends of chain affiliated providers and their relation to quality of care.
10.	✓		Survey Team Composition - Review and comment on a proposal to establish a model for survey team size and surveyor disciplines.
11.	✓		Orientation Program for Newly Employed Health Facility Surveyors - Review the objectives and content of the orientation program.
12.	✓		Credentialing of Surveyors - Review and comment on a proposal to establish a process for the credentialing of surveyors.

Part II

Please provide in the spaces below information concerning your organization's contact person and presentor(s). If you would like to participate in discussions for more than 8 topics, please indicate the topic number and comentator on the back of this form.

Contact Person

Name: John J. Jarrell, Director

Health Facilities Evalaution Division

Address: 2019 Washington St., E. P&G Building

Charleston, WV 25305

Telephone Number: Area Code (304) 348-0050

Organization: WV Dept. of Health - Health Facilities Evaluaiton Division

Presentor(s)

Topic Number: 1	Commentator: John J. Jarrell or Designee(s)
Topic Number: 2	Commentator: ditto
Topic Number: 3	Commentator: ditto
Topic Number: 4	Commentator: ditto
Topic Number: 5	Commentator: ditto
Topic Number: 6	Commentator: ditto
Topic Number: 7	Commentator: ditto
Topic Number: 8	Commentator: ditto

Part III

Additional Topics: (Please use additional paper, if necessary.)

Please provide us with your reactions to the above topics, additional areas that you would like discussed, or specific proposals you may wish to present.

Please send the completed form by January 31 to:

The Health Care Financing Administration
Health Standards and Quality Bureau
Office of Survey and Certification
Attention: Theresa Spady
2-D-2 Meadows East Building
6325 Security Boulevard
Baltimore, Maryland 21207

file

[COMMITTEE STAFF NOTE: This document has been excerpted for brevity.]

January 31, [illegible]

[January 31, 1986]

Mr. W. Scott Sprinkle, Director
Office of Regulatory Services
Georgia Department of Human Resources
878 Peachtree Street, N. E., 8th Floor
Atlanta, Georgia 30309

Re: Comprehensive Evaluation Report - 1985

Dear Mr. Sprinkle:

We are transmitting the enclosed report for your review and comment. Any comments you wish to furnish will become an addendum to the report. We request a reply within 30 days of the receipt of this report.

We appreciate your cooperation in this matter.

Sincerely yours,

/s/

Clarence J. Boone
Associate Regional Administrator
Division of Health Standards and Quality

Enclosure

2/3/86 ES

gm:rewrites01-31-86

COMPREHENSIVE EVALUATION REPORT

GEORGIA

OCTOBER 1, 1984 - SEPTEMBER 30, 1985

I. INTRODUCTION

The overall objective of the comprehensive evaluation report is to delineate the performance of the survey agency in carrying out its survey and certification respnsibilities. Those responsibilities are defined by the 1864 Agreement between the State and the Secretary of Department of Health and Human Services and Section 1902 of the Title XIX law. Both Medicare and Medicaid regulations, along with HCFA operating instructions are provided to the States. The national performance indicators covered later in this report are used and augmented by the regional office in assessing state survey agency performance as measured by the law, regulations and HCFA instructions.

A. Organization

The Georgia State Survey Agency, the Regulatory Services Section is a major operating component of the Office of Regulatory Services, Division of Administrative Services, Georgia Department of Human Resources. We have attached organizational charts (Exhibit A) to assist the reader's orientation to Georgia's organizational structure.

Within the Office of Regulatory Services, Standards and Licensure Section, the work is carried out in three regional offices (two of which are located in Atlanta, the other being in Albany). These are operating offices of the program (i.e., decisions are made regarding survey team size and composition, time frames, quality, employee evaluation, etc.). These regional offices are responsible for the planning, program direction and technical supervision of the survey and certification process.

Since a majority of the recently surveyed non-complying facilities were in the Southern Region, this raises questions concerning whether there is adequate supervision of the work of the Southern Region, both in the Albany Office and by the Regulatory Services Section Director. Any reorganization considerations should address increased supervision and/or monitoring to assure improvement in this area. However, more management emphasis on aggressive enforcement of health and safety requirements will be more effective than tinkering with organizational structure.

The State Agency (SA) includes a separate laboratory section, which is located within the same Office of Regulatory Services. The SA also contracts out with the Fire Marshall's Office for the Life Safety Code surveys. The presence of these additional agencies requires more procedures and controls regarding document flow, time frames, etc., to assure accountability.

B. Budget FY-1984 10/1/85 - 9/30/85

During the above period the Georgia Survey Agency was initially approved for the amounts listed below for certification activities in both Title XVIII and Title XIX programs:

Title XVIII	984,234	(Medicare)
Title XIX	900,678	(Medicaid)
	1,884,912	

The Georgia Licensure Program contributes substantially to overall survey costs. Salaries of surveyors are supported by 12% licensure funds for health surveyors and 64% licensure funds for laboratory surveyors. These data reflect the multiprogram nature of the survey agency in distributing the cost among various programs (these percentages reflect only personnel cost). HCFA funded the following personnel:

Professional	47.43	Full-time Equivalents (FTEs)
Clerical	10.57	FTEs
Total	58.00	

Georgia utilizes a multi-discipline survey team in performing its institutional surveys, i.e., hosptials and long term care facilities. The team usually includes an administrative surveyor (team leader) and one or more nurses. A dietitian, pharmacist, social worker and laboratorian are included as available and when appropriate. Life safety surveys are coordinated with the health survey, but are conducted approximately 30 days earlier. A recreation specialist is also available for survey and/or consultation statewide.

C. Certification Workload

The state survey agency is responsible for conducting and processing regular surveys of the following types of providers or suppliers:

Hospitals (accredited)	132
Hospitals (non-accredited)	61
Home Health Agencies	71
Rural Health Clinics	26
Independent Laboratories	77
Rehabilitation Centers (OPTs)	36
Portable X-ray	1
ESRDs	44
Ambulatory Surgical Centers	6
Comp. Outpatient Rehab Facilities (CORFs)	3
Hospices	11
Skilled Nursing Facilities	280
Intermediate Care Facilities (excluding swing beds and IMRs)	49
IMRs	11
	808

Performance Indicator (17) - The time frames and the corrective action proposed for the cited deficiencies are reasonable

In considering both the file review completed by Regional Office staff at the State Survey Agency and the results of recent Federal direct surveys, we want to review with your office the use of some of the federal regulations in bringing about compliance or attempting to keep facilities in compliance. Although the State Agency usually identifies true repeat deficiencies, there are recent examples of facilities with histories of very bad performance for a period of several years where an almost continuous period of non-compliance at the standard level has existed with only brief periods of marginal compliance. Sometimes, the standard level deficiencies that are not met are the same from year to year and sometimes they are different standards, but the result is somewhat the same; there are substantial periods of non-compliance with many important federal nursing home requirements throughout a large part of the certification period.

For Title XIX only nursing homes, both skilled and intermediate care, 42 CFR 442.105(a) thru (d) needs to be reviewed more closely and a more stringent application made. With facilities having histories of poor performance, you might want to develop a written justification of a finding that "the facility's deficiencies, individually or in combination...seriously limit the facility's capacity to give adequate care." This fact is more often true than the rarer circumstance where the deficiencies "jeopardize the patient's health and safety." This possible conclusion suggested in section (a) of the above regulations, that the facility's deficiencies...seriously limit the facility's capacity to give adequate care," needs supporting documentation from sections (b), (c), and (d) of the same regulation (442.105). We suggest the following considerations:

(b) "The agency finds acceptable the facility's written plan for correcting the deficiencies."

You should consider not accepting routine plans of correction that have in the past failed to maintain compliance at facilities with histories of very bad performance. Examples: (1) More intensive, specific or frequent consultation, (2) Performance monitoring that could result in an increase in nursing, dietary, housekeeping staff, etc., (3) Putting out the condition of governing body and management, (4) Direct communication with the governing body or absentee owner, chain headquarters, etc., (5) Encourage the facility to obtain consultation from their own source or the State Agency, (6) Well documented or regional differences in pay for professional staff or disciplines, where there are recurring staff shortages, (7) Other necessary actions appropriate to the circumstances that would cause the facility to develop a more specific plan of correction with a greater likelihood of success.

(c) and (d) - (c) applies to different standard level deficiencies recurring from year to year and (d) applies to the same standard level deficiency recurring from year to year. In both cases the State

> Agency from year to year and (d) applies to the same standard level deficiency recurring from year to year. In both cases the State Agency has to document that the deficiency recurred for reasons beyond the facility's control or despite intensive efforts to comply. If the facility is not cooperative or not making their best effort, the State Agency should not certify the facility or recommend it for a new agreement.

There is also a similar regulation for Medicare certified nursing homes at 42 CFR 405.1908(d).

Recommendation: Review the above Federal regulations 442.105 for XIX SNFs and ICFs and 405.1908(d) for Medicare SNFs. Discuss and review these regulations with your staff. Staff from the Regional Office will be glad to participate. You may have other methods or procedures that you can use in applying the above regulations to facilities that are historically non-complying.

Resolution: The State Survey Agency agreed to give more attention to Federal regulations 442.105 for Medicaid SNFs and ICFs and 405.1908(d) for Medicare SNFs. Staff from HSQ/RO did participate in the last quarterly staff development session reviewing this recommendation and the results of the field work. The State Agency has recently recommended termination of a XIX only facility with a history of poor compliance. This demonstrated an improved understanding of the above regulations. The HSQ/RO will continue to work with the State Agency to help develop a common understanding of compliance.

Performance Indicator (18) - Life Safety Code waivers are reviewed for legitimacy justified on the grounds of compensatory factors, financial hardship, and no hazard to patient health and safety

The only recommendations regarding LSC waivers were made in Performance Indicator"3", Criterion 4.

The following miscellaneous recommendations were made:

(1) The administrative surveyors in Standards and Licensure need to be consistent in numbering the buildings, when more than one exist, on the Crucial Data Extract sheet for LSC. The example observed was Northwest Georgia Regional ICF/MR. Please review with all administrative surveyors the need to number the buildings consistently on 2567s and CDEs.

(2) Laboratory Section - There were few problems with the laboratory files, but in two (Mid Georgia Pathology (11-8001) and Doctor's Lab (11-8040)), the pages of the 2567 were not numbered making it difficult to know if the 2567 was complete without checking it against the Survey Report Form. Please remind staff of the need to number pages on 2567s.

Resolution:

The State Agency agreed to be more attentive to the proper numbering of buildings and pages. Recent kits received in the Regional Office reflect improvement in this area.

Criterion VI - Complaint Management

Performance Indicator (2) - System for Controlling Complaints

The log system used by the State Survey Agency seems to work well, however there needs to be better coordination and follow-up on patient abuse complaints that are referred to Robert Maifeld. There was no further response to two complaints (#0536 and #0496). Also complaint #0535 received a response from Mr. Maifeld, but did not appear to be investigated at the facility or referred on to the surveyors in the region for either investigation or follow-up.

Recommendation:

Policies need to be developed to assure that patient abuse complaints are actually investigated onsite at the facility and that a complaint investigation is completed. This information should result in Statements of Deficiencies (HCFA-2567) and follow-up visits or follow-ups on subsequent surveys. I am sure it was never intended for the additional assistance of a coordinator for Long Term Care Patient Abuse complaints to interrupt the follow-up and closure that is necessary on any complaint. We would also suggest that you adopt a system of quick identification of JCAH complaints and those referred by the HSQ/RO. The log lends itself very handily to such a notation system.

Resolution:

At the time of the December 10-11, 1985 follow-up of the SAEP, conducted at the State Survey Agency, we became aware of the appointment of a new section chief in the Abuse Monitoring Section and a staff person in that section. This action and the State Agency's response to the recommendation should assure improved handling of complaints with a patient abuse component, howeer further SAEP reviews will need to establish if the log and coordination result in improved handling of complaints.

Performance Indicator (8)

The recommendation suggested (2) above, if implemented will assure that allegations are substantiated or not and that 2567s result when appropriate.

Recommendation: See Performance Indicator (2) above.

Resolution:

This needs further monitoring in 1986 to assure that the system works properly in investigating complaints.

Performance Indicator (9) - Analysis and Summary of Complaints

The pilot complaint project had a very good annual summary with data that would be useful to surveyors and survey managers, however, there are no policies or requirements for the annual reporting.

Recommendation:

The project should be formally evaluated and changed if and where necessary and accepted for implementation. This should result in policies being developed and manualized in the ORS-S and L Section Policy and Procedure Manual or other directive systems to assure that at a minimum the Federal requirements are met with regard to complaint investigations.

Resolution:

The State Agency responded that additional staff would be recruited to augment the complaint monitoring function and that the function would be placed under the supervision of the Quality Assurance Program; action to be completed by September 30, 1985. None of this action had been completed as of the December 10-11, 1985 follow-up visit. An evaluation of the complaint system must continue into 1986 with a view to its efficient operation, the formalization of the complaint system and the use of the summaries and reports for management decisions and/or training.

Field Monitoring Surveys

Seventeen Federal monitoring surveys were conducted during July and August 1985, which resulted in seven facilities being found out of compliance that were found in compliance by the State (five nursing homes, one home health agency, and one hospital). Follow-up surveys made by Regional Office staff have been conducted and all facilities are back in compliance except for Chapman's Convalescent Center in Hazlehurst, which is scheduled for an additional follow-up survey in early January. The HSQ/RO sent letters notifying all seven facilities of the intent to terminate or withhold Federal Financial Participation. Consultation visits were made by the State Agency in several instances, where requested and time permitted.

Four of the nursing homes had patient types which contributed to the non-complying situation. There was a long standing inability of the staff to care for and provide treatment to a patient population which has a high percentage of patients with either a primary psychiatric diagnosis or a diagnosis of mental retardation. A second factor present in four of the non-complying nursing homes was a reluctance or inability to stay in compliance. There were minimal plans of correction in many cases.

Only one of three Home Health Agencies was out of compliance and that facility had a good understanding of what was necessary to come in compliance and did so rather quickly.

One of the two hospitals surveyed was out of compliance, but only in the laboratory condition. This condition was found corrected at the time of the follow-up survey.

During the first quarter of FY 1986, we now note that all five direct Federal surveys of ICF/MRs in the State were found out of compliance with active treatment requirements. These findings differ markedly with State findings. HCFA consultants have also found 2 out of 2 of the State's Psychiatric Hospitals out of compliance.

The most significant recommendations made to the State Agency were as follows:

Long Term Care

1. The State Agency must work with the Department of Medical Assistance to alert them to the serious repercussions concerning Medicaid certification when placing a high percentage of patients with psychiatric diagnosis in facilities which do not have sufficiently trained staff to meet the needs of such patients.

2. The State Agency must work with the Department of Medical Assistance to formulate a strategy to effectively deal with borderline, non-complying skilled nursing facilities and intermediate care facilites. It is apparent from these monitoring surveys that there are some long-term care facilities that are habitually out of compliance with the regulations, bringing themselves into compliance only temporarily prior to State Agency follow-up visits. Subsequently, they become out of compliance. These Medicaid certified facilites should be identified and a special procedure should be established either to bring them into permanent compliance or to initiate an adverse action against their Medicaid participation. The S/A should develop a list of these providers, indicating actions initiated and current status.

3. The State Agency must define and implement criteria for acceptable plans of correction as expressed in the State Operations Manual, Section 2728. Briefly, the provider's Plan of Correction must:

1. Be responsive to the cited deficiency.
2. State and describe the end result.
3. Indicate resonable completion dates.
4. Fully describe the methodology along with the appropriate action steps to accomplish complete and permanent corrective action.

4. The State Agency should ensure that surveyors prepare deficiencies in accordance with the State Operation Manual, Section 2728. During our analysis of monitoring surveys, we noted that the State Agency frequently writes program deficiencies in a complete and well documented fashion. In contrast, there were some instances encountered during our analysis in which State surveyors expressed deficiencies in a broad conclusive term without indicating the specific reasons for reaching that determination. For example:

   1. Documentation does not verify an active nursing rehabilitation program is being carried out Ref.: Cordele Royal Care Center.

   2. Linens were not handled in a manner to minimize or prevent the spread of infection (Ref. Ideal ICF),

5. The State Agency should increase its survey activity in dietetic services particularly in the area of nutritional adequacy of diets, sanitation and documentation of nutrtional care of patients.

6. The State Agency should proceed with plans already established to employ a surveyor in the Southern Region who will be principally responsible for surveying social services and patient activities.

Home Health Agencies

1. The State Agency should institute an evaluation program with survey personnel assigned to home health agencies to ensure that sufficient time is allocated to surveyors to complete the on site survey process in a complete and thorough manner. We believe that in most instances one day would be a proper amount of time to conduct a survey of a home health agency.

2. The State Agency should upgrade their survey procedures for:

   1. Inservice education of agency personnel.

2. Case conferences to ensure liasion with all personnel providing health services.

3. Home health agency evaluation programs.

Rural Health Clinics

1. The State Agency should upgrade their survey procedures for program evaluation in rural health clinics.

Resolution:

A report of the fieldwork with emphasis on the non-complying nursing homes was made by Regional Office staff before the State Survey Agency and another meeting which involved the Title XIX or Medicaid Agency. Discussion was directed toward all the findings and recommendations, but with emphasis on the patients with psychiatric or mental retardation diagnoses and the marginally complying facilities (in and out of compliance repeatedly).

Staff from the Georgia Medicaid Agency met also, along with Survey Agency staff at the HSQ/RO to better understand the termination process and achieve a better understanding of compliance.

The State Survey Agency provided a plan of action in response to the recommendations from the fieldwork. A quarterly in-service meeting with all disciplines was conducted on October 7, 1985, at which time the fieldwork was reviewed as well as the recommendations and the termination process. Continued input is necessary by HSQ/RO staff to all future quarterly in-service meetings to assist the State and monitor the necessary training and communication that might bring State and Federal survey findings into closer agreement. The initial cooperation on the part of the State Survey Agency has been good, but they need the cooperation of the Medicaid Agency (Inspection of Care and termination action) and increased training/communication with the HSQ/RO to assist them in their plan of action resulting from the recommendations of the fieldwork.

The overall lack of agreement between the Federal direct surveys and the State surveys mandate a more aggressive posture on the part of the State Survey Agency in dealing with any non-complying facility, but particularly with the habitual offenders. We expect State action to demonstrate improvement in this area no later than April 1, 1986.

Part III. STATE AGENCY INITIATIVES

The Georgia's State Survey Agency is to be commended for requesting IBM PC computers and initiating the search/development for software packages to better schedule surveys, handle correspondence and review survey data.

Criterion IV - Processing of Surveys and Certifications

The State Survey Agency has made improvements in the certification times (i.e., survey date until State Agency sign off on the certification kit) of all providers and suppliers except JCAH hospitals, 18/19 SNFs, IMRs, and Rural Health Clinics, which have increased from the second to the third quarter of the calendar year. The time elapsed between date of the survey exit interview and certification should not exceed 45 days, however it does for five different facility types as displayed earlier in Table 12 of the MMACS.

The only other problem noted in this criterion is a failure of the State Survey Agency to supply information timely to the HSQ/RO upon written or verbal request. Although not typical of the State Agency communications, it must be mentioned.

Criterion V - Valid Surveys and Sustainable Certification Decisions

A file and program review did not detect that the Georgia State Survey Agency had any major problems in ensuring that surveys and certifications are documented, appropriate and consistent with program law, rules and policies. These findings are, however, not consistent with the findings of our recent fieldwork in which five of the eight long-term care facilities that underwent Regional monitoring surveys were not in compliance with requirements and have been under termination action concerning their Medicaid or Medicare Program participation.

Although we discussed under Performance Indicator 17 above some strategies for dealing with facilities with histories of poor performance, the results of the Regional Office fieldwork were so disturbing as to suggest other action that should be taken by Standards and Licensure Section, Office of Regulatory Services. We asked for a more aggressive role for your Quality Assurance Unit and perhaps a more timely expansion of their role. This should include an earlier implementation date of their expanded role of performing surveys of problem facilities or follow-up surveys of any questionable facilities, particularly those in the southern region.

Our main concerns were discussed in Performance Indicator 17 and involve strategies for dealing with facilities that have histories of poor performance also those with many recurring deficiencies and repeat deficiencies that are shown corrected by "substantial progress" or are corrected for only brief periods of time after an Automatic Cancellation Clause (ACC) follow-up survey. Some recommendations were made to the State Agency to interpret more stringently 42 CFR 442.105(a) thru (d) (for Medicaid only nursing homes) and 42 CFR 442.1908(d) (for Medicare skilled nursing homes). A more careful application of these regulations should strengthen the State Survey Agency's performance in enforcing federal requirements.

Continued monitoring of Criterion V is necessary in FY 1986.

PAST PRESIDENT'S REPORT
Board of Directors' Meeting
Washington, D.C.
February 4, 1986

ASTHO EXECUTIVE COMMITTEE MEETINGS

On September 17, 1985, a meeting between the ASTHO Executive Committee and Secretary Heckler was held as a follow-up to the August 6, 1985 letter from this Association to Secretary Heckler.

On November 20, 1985, separate meetings were then held in Washington D.C. between the Executive Committee and William Roper, Presidential Health Advisor, and with C. McLain Haddow, Acting Administrator, HCFA. I was invited to accompany the Executive Committee to these two meetings.

Issues which served as the purpose for these meetings involved the 1864 Agreement, federal audits of Medicaid programs, PaCS and the termination procedures. The ASTHO Executive Committee includes State Health Officials from Arizona, Connecticut, Colorado, Oklahoma, Oregon, South Carolina and Washington.

In general, discussion centered around the working relationships between state survey and certification agencies and HCFA. Of particular concern was the negative attitude of HCFA for a federal/state partnership in the establishment of new or revised programs and policies. The lack of negotiations in the 1864 Agreement was mentioned as a prime example.

Executive Committee Members pointed out at the Roper meeting that there was a need for a high level of contact between state health officials and HCFA policy maker and that HCFA should look upon the states as laboratories to improve survey and certification activities. The Executive Committee also mentioned the care gap caused by the DRG system between hospital discharges and home health care especially as it related to denial of home health agency claims.

Mr. Roper indicated that he would take these messages to the newly appointed Secretary of HHS and the HCFA Administrator, to be considered as a priority.

Acting Administrator Haddow was, however, less inclined to consider the Executive Committee's views. He bluntly stated that there is no partnership between HCFA and the states under the 1864 Agreement, that it is a contract and that the Bureau of Standards and Quality was carrying out the survey and certification program as instructed by HCFA policy and management. Executive Committee members reacted very strongly to this statement and questioned HCFA's attitude. The Executive Committee also hit hard at the inconsistency of messages from Regional Offices to the states and that in fact states needed to be considered as partners with HCFA in areas of common interests.

There was an agreement reached that meetings should be held quarterly or as frequently as necessary between HCFA and ASTHO to discuss general policy matters relating to survey and certification.

U.S. General Accounting Office (GAO)

As instructed at the Philadelphia post Board meeting GAO survey reports on SNF/ICF regulations directly affecting patient care were forwarded to the GAO's Kansas City office. Only Colorado, Minnesota and Wisconsin surveys were completed and sent. In a follow-up conversation the GAO representative, James J. Hoffman, also expressed interest in the documentation of standard level deficiencies required under 405.1908 and 442.105. A copy of the Wisconsin procedure for obtaining such documentation was requested by Mr. Hoffmann.

Tax-Exempt Status of AHFLCD

On November 18, 1985, the Internal Revenue Service issued an Employee Identification Number to the AHFLCD, Inc. Assignment of this number by the IRS is a prerequisite in filing for tax-exempt status as a nonprofit organization. On January 17, 1986, Form 1023 (application for Recognition of Exemption) was forwarded to the IRS and a ruling or determination letter recognizing the Association's exempt status was requested. Any organization (other than a private foundation) having annual gross receipts normally of not more than $5000 is exempt by statute. Completion and filing of Form 1023 is the means for making that determination. Upon receipt of this determination I will notify the Board.

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

4/12

Memorandum

HCFA File

Date FEB 12 1986

From Richard P. Kusserow
Inspector General

Subject OIG Draft Audit Report - Use of the Medicare/Medicaid Automated Certification System - ACN: 03-60154

To Henry R. Desmarais, M.D.
Acting Administrator, Health Care
Financing Administration

Attached for your review and comments is a draft audit report on the results of our review of HCFA's use of the Medicare/Medicaid Automated Certification System (MMACS) to monitor State surveys and certifications of long-term care facilities participating in Medicare and Medicaid.

The report points out that MMACS can be an effective management tool, but in operation its data is often out of date and, therefore, inaccurate. As a result, HCFA does not use MMACS to plan national strategies for monitoring State survey and certification activities.

We are recommending that MMACS data be updated and kept current and that it be the basis for HCFA's management decisions regarding surveys and certifications of long-term care facilities. In this regard, we are recommending that a national strategy be developed using MMACS to hone in on long-term care facilities that have not been surveyed within regulatory time frames or have exhibited aberrant patterns of care. These facilities should then be subject to financial disallowances, HCFA inspections or soon-to-be-authorized intermediate fiscal sanctions as warranted.

If you or your staff wish to discuss the material contained in this draft report, please let me know or contact F.J. Majka, Assistant Inspector General for Audit. We would appreciate receiving your comments within 30 days from the date of this memorandum.

Attachment

FINAL VERSION

USE OF THE MEDICARE/MEDICAID AUTOMATED CERTIFICATION SYSTEM

ACN 03-60154

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

Office of Inspector General

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EXECUTIVE SUMMARY

This draft audit report summarizes our review of HCFA's use of the Medicare/Medicaid Automated Certification System (MMACS) to monitor State surveys and certifications of long-term care facilities participating in Medicare and Medicaid. These programs spend over $14 billion annually to provide services to nearly two million patients residing in long-term care facilities. As the Federal manager of both programs, HCFA is responsible for ensuring that these facilities are safe and provide high quality care. MMACS was established to assist HCFA fulfill this responsibility by providing a centralized data bank containing a wide array of survey and certification information gleaned from survey reports, corrective action plans and other related documents.

We agree that a centralized data bank such as MMACS is needed to enable HCFA to develop national strategies to monitor the activities of States which are directly responsible for surveying and certifying long-term care facilities. An effective MMACS, for example, would enable HCFA to readily identify all long-term care facilities that have not been surveyed or have demonstrated patterns of aberrant care.

Our review in eight regions, however, has shown that MMACS is not an effective management tool primarily because it does not contain current and, therefore, accurate data. As a result, a national strategy to monitor State survey and certification activities has not been developed and regions are left to monitor as best they can. Our surveys and previous audits have shown that regional efforts are not totally successful.

We are recommending that HCFA use MMACS to develop and implement a national strategy to ensure that all long-term care facilities are surveyed annually and to identify facilities that, on the basis of past patterns of care, should be selected for HCFA inspections and intermediate sanctions. Before this can be accomplished, however, HCFA must ensure that MMACS data is as current as possible.

MMACS - DESIGNED TO BE AN EFFECTIVE MANAGEMENT TOOL

HCFA's mission is to promote the timely delivery of appropriate, quality health care to its beneficiaries -- about 50 million of the nation's aged, disabled and poor. In carrying out this mission, HCFA is responsible for ensuring that medical facilities participating in Medicare and Medicaid meet established standards. Facilities must be structurely safe, provide for a sanitary environment, be well staffed and provide high quality care. Annual surveys, certifications and provider agreements are required to ensure that facilities meet these high standards. Medicare and Medicaid pay over $90 million a year for certification related activities to help safeguard the health and safety of patients.

MMACS was designed to play a key role in HCFA's monitoring of State survey and certification activities. Implemented during the early 1970's in response to an ever increasing demand for a centralized data source, MMACS is an automated data retention system that provides information on the quality, quantity, and availability of health care related services in the United States. The data is entered into the system through a dispersed remote data entry tele-transmission network located in the 10 HCFA regional offices. Costs to operate the system total over $2 million annually.

The information stored in MMACS is essentially a by-product of the State Agency conducted Medicare/Medicaid certification process which covers about 42,000 medical facilities of which about 19,180 are long-term care facilities. The data included is derived from completed survey reports, provider applications, plans of correction and other related certification documents. According to a brochure published by HCFA, the data available on the certification process is virtually unlimited and the extent of its usefulness is controlled by the ingenuity and resourcefulness of MMACS users.

MMACS, like any computerized system, is only as good as the information stored in it. In this regard, HCFA is required to evaluate the system every three years. The 1982 evaluation stated that the original requirements and objectives of this network were still valid and were being satisfied efficiently. HCFA recommended continued operation of the system. In its latest evaluation dated March 13, 1985, HCFA's conclusions and recommendations were identical to those stated three years previously.

SCOPE OF AUDIT

Our review was made in accordance with standards for governmental auditing. Our primary objective was to determine if MMACS was an effective management tool for monitoring the certification of long-term care facilities participating in the Medicare and Medicaid programs. In making this determination, we extracted data from MMACS identifying long-term care facilities not surveyed during the 15 month period ended January 1, 1985. To verify the accuracy of this data, we visited 8 HCFA regional offices and reviewed survey files submitted by 14 States. Lastly, we extracted similar data from MMACS as of October 25, 1985, to determine whether any significant changes had occurred.

MMACS IS NOT AN EFFECTIVE MANAGEMENT TOOL FOR MONITORING LONG-TERM CARE FACILITIES

Contrary to HCFA's conclusion that MMACS is efficiently meeting its objectives, our surveys in eight HCFA regional offices show that MMACS is not an effective management tool for use in monitoring surveys and certifications of long-term care facilities. Results of facility surveys which are required to be performed annually are not input into MMACS timely; thus, the system's output is out of date and, therefore, often unreliable.

HCFA regional officials perceive this to be a major deficiency within the system and attempt to monitor State survey and certification activities through other means available to them. Our surveys and other recent audits have shown that the regional offices have not always been successful in these attempts.

MMACS Shows Thousands Of Long-Term Care Facilities As Not Being Surveyed Within 15 Months

Prior to passage of the Omnibus Budget Reconciliation Act (OBRA) of 1981, the Social Security Act required States to have provider agreements with long-term care facilities participating in Medicaid and Medicare that generally did not exceed 12 months. Department regulations implementing the provisions of the Social Security Act required annual surveys as a precondition for annual certifications, which in turn were a precondition for annual provider agreements.

The statutory requirement for annual surveys, certifications and agreements was eliminated by Section 2153 of OBRA. The effect of this change was to allow the Department the flexibility to either continue with the regulatory requirement for annual surveys, certifications and agreements or change the regulations as deemed necessary.

HCFA reacted to OBRA by establishing a flexible survey cycle and by publishing a Notice of Proposed Rule Making (NPRM) dated May 27, 1982, removing the annual survey, certification and provider agreement requirements in favor of a flexible cycle. Apparently in reaction to the NPRM, Congress enacted two provisions -- Section 135, Tax Equity and Fiscal Responsibility Act of 1982, (Public Law 97-248) and Section 146, Continuing Resolution Appropriations for FY 1983, (Public Law 97-276) -- that prohibited the Department from issuing a final rule changing the regulations. Establishing a moratorium provided the opportunity for further review, revision or withdrawal of the proposed regulations.

In January 1983, HCFA directed its regional offices to reinstitute the annual requirements and to "move toward stricter compliance with all the regulatory provisions..." According to this instruction "a liberal phase-in period would be expected under the circumstances". This direction signaled HCFA's intent to not change the regulatory requirements for a mandated annual cycle. This is evidenced by the fact that although the Congressional moratoria expired or August 28, 1983, HCFA had not issued a final ruling on its NPRM.

Thus, when we began our review in January 1985, two years had passed since HCFA reiterated its intent to require annual surveys. Even giving a "liberal phase-in period" as mentioned in HCFA correspondence, surveys should have been conducted and entered onto MMACS during this interval. We found, however, that as of January 1, 1985, there were 3,849 long-term care facilities out of a total of about 19,180, that, according to MMACS, were not surveyed within the last 15 months (we used 15 months rather than the 12 month regulatory requirement to recognize a few regulatory exceptions and to account for time to enter survey results onto MMACS). This extremely high number of unsurveyed facilities indicated that either there was noncompliance with Federal regulations occurring at the State level, or MMACS contained outdated and inaccurate data.

To determine the true situation with regard to both MMACS and State survey and certification activities, we visited eight HCFA regional offices and reviewed survey files from 14 States. These States accounted for 66 percent of the facilities identified by MMACS as being out of compliance with Federal regulations.

At the HCFA regional offices, we found that the general perception of MMACS was that it was outdated, inaccurate, and could not be relied on as a useful management tool. Some of the more typical views expressed were as follows:

... Regional officials recognize that MMACS data is unreliable and out of date and that the system's usefulness as a management tool is significantly limited.

... MMACS is not used as a management tool to monitor State survey functions because the information in it does not represent current survey and certification information on all facilities. This region relies on a manual system for monitoring States.

... MMACS is used to backup a manual system that is more current and more responsive to management needs.

For 1,568 facilities identified by MMACS as not being surveyed within the last 15 months, we reviewed survey files at HCFA regional offices and, where necessary, at appropriate State Survey Agencies. We found the regional perceptions to be basically an accurate reflection of MMACS. Data was not current and therefore, not a reliable indication that the survey process was breaking down and in need of review and improvement. We noted that, contrary to what was recorded on MMACS for the 1,568 facilities, 1,506 (96 percent) had been surveyed within the last 15 months but the results not entered onto MMACS. As shown in Exhibit 1, the rate of error was extremely high in each of the eight regions reviewed.

To determine why the MMACS data base was not current, we reviewed the processing of survey results using three key milestone dates: the date survey was completed, the date survey results were received in HCFA, and the date results were entered onto MMACS. Our statistical sample of 230 surveys showed that between 15 and 583 days were needed to complete processing of survey results. The average was 107 days and consisted of:

... 73 days needed by State Survey Agencies to forward results to HCFA.

... 34 days needed by HCFA to enter the results onto MMACS upon receipt from State Survey Agencies.

According to the State Operations Manual, HCFA requires States to forward survey results within 45 days after the survey exit interview with the facility surveyed. States routinely failed to meet this requirement. HCFA has not established a timeframe in which regional offices are expected to input survey results upon receipt from State Survey Agencies. We believe, however, that the 34 days used to complete this process is unreasonably long.

Our sample has shown that improvements are needed in both the State and Federal segment of the processing cycle if MMACS is to become the effective management tool it was designed to be. And there are several indications that such a monitoring system is needed. Our surveys, for example, showed that while MMACS could not be fully relied upon, neither could the manual systems used by HCFA regional offices in lieu of MMACS. As noted in Exhibit 1, 5 of the 14 States reviewed were not properly surveying all long-term care facilities.

Although the primary purpose of our surveys was not to develop the amount of Federal funds provided to these facilities during periods of noncompliance, we are in the process of developing this information in Connecticut and will report on it separately. Preliminary indications are that facilities received about $1.3 million while in a noncompliance status.

Other indications of State noncompliance with Federal regulations and HCFA guidance can be found in recent audits made in Illinois and Indiana. These reviews will also be reported on separately but preliminary results show that a total of $74.9 million in Federal funds were reimbursed to 271 long-term care facilities which were not surveyed timely.

HCFA Recognizes Need To Monitor Survey Activities But Review Methods Need Improvement

HCFA recognized the need for surveillance of State survey and certification activities. In July 1985, HCFA informed its regional offices that during fiscal year 1986 each region had to perform a review in one State to ensure that annual surveys of long-term care facilities are being carried out by State Survey Agencies. In September 1985, the regional offices were provided with a review guide entitled "Financial Management Review Guide for Provider Agreements (PA) with Long-Term Care (LTC) Facilities". The regions were instructed that beginning October 1, 1985, it will be necessary to initiate the appropriate disallowance action for facilities which have not been surveyed.

One problem with this one-State-per-region approach is that it provides no sense of urgency to the regions for upgrading MMACS. The review guide does not provide adequate instructions on how the States to be reviewed should be selected and basically leaves the selections up to the regions.

Considering that MMACS was established to provide a centralized data base to facilitate selections of this nature, HCFA should have emphasized its use in this instance. Our biggest concerns with this review method, however, deal with limiting reviews to one-State-per-region and confining disallowances to October 1, 1985 and beyond.

National Review Strategy Needed

An inherent weakness in this one-State-per-region approach is that it precludes HCFA from planning a national, rather than regional, strategy to eliminate the problem of uncertified long-term care facilities. If a national strategy was adopted, HCFA would first identify the States that, based on available management information, had the highest incidence of noncompliance. These States would then be selected for review regardless of what HCFA region they were located in. This could very well mean that some regions would be required to review two or more States while in other regions, one State might suffice. By adopting a regional strategy, HCFA had no assurance that States with the highest incidence of noncompliance would be selected for review.

We compared the 10 States selected for review by HCFA regional offices to the 10 States with the largest number of long-term care facilities not surveyed within 15 months according to MMACS as of October 25, 1985. We found the following:

States With Largest Number of Facilities Not Certified		States Selected For HCFA Review	
State	Facilities	State	Facilities
New York	640	New York	640
Indiana	269	Michigan	222
Massachusetts	258	California	202
Texas	258	Oregon	106
Pennsylvania	240	Louisiana	77
Michigan	222	Maryland	41
California	202	Maine	30
New Jersey	200	Colorado	20
Ohio	195	Nebraska	17
Illinois	165	Georgia	9

As could be anticipated, adoption of a regional, rather than national, strategy resulted in many States with large numbers of long-term care facilities potentially out of compliance with Federal regulations not being included in the planned review. As shown above, 7 of the 10 States with the largest number of facilities not surveyed are excluded while States such as Colorado, Nebraska and Georgia with relatively few unsurveyed facilities are included in the planned review.

We also noted that some regions, particularly Regions I, IV and VII, appear to have selected States where the incidence of noncompliance with the annual survey requirement is low compared to other States within the same regions.

		MMACS	
Region	States Selected for Review	Facilities Out of Compliance	State Ranking in Region
I	Maine	30	4 of 6
II	New York	640	1 of 2
III	Maryland	41	3 of 6
IV	Georgia	9	4 of 8
V	Michigan	222	2 of 6
VI	Louisiana	77	2 of 5
VII	Nebraska	17	4 of 4
VIII	Colorado	20	1 of 6
IX	California	202	1 of 4
X	Oregon	106	1 of 4

Region I is a good example. According to MMACS, Maine had 30 facilities not surveyed within a 15 month period as of October 25, 1985. This compares to Massachusetts with 258 facilities out of compliance; Connecticut with 138 facilities out of compliance and where we know from our survey that problems do exist at the State level; and Rhode Island with 110 facilities out of compliance.

Unlike our initial MMACS application of January 1985, we did not review survey files to verify the accuracy of MMACS data. Therefore, we do not know, nor does HCFA management know, whether States selected by regions for review were the most appropriate selections. As shown in Exhibit 2, however, there was only a slight drop in the number of long-term care facilities identified as not surveyed within 15 months -- 3,849 facilities in January 1985 and 3,842 facilities in October 1985.

Disallowance Actions Should Begin Earlier

HCFA's review guide mentioned that its interim policy of permitting flexible survey cycles was in effect during fiscal years 1981 through 1984. According to the guide, all facilities must be surveyed and found in compliance during the fiscal year 1985 phase-in period. Beginning with fiscal year 1986, it will be necessary to initiate the appropriate disallowance action for those facilities which have not been surveyed. The review guide used as its basis for these timeframes a HCFA memorandum dated August 9, 1984, which reaffirmed the annual survey requirement.

By extending the interim policy on flexible survey cycles to September 30, 1984, HCFA, in our opinion, has prolonged potential noncompliance with Federal regulations by State Survey Agencies, and ignored its own instructions which indicated that full compliance with the annual survey requirement was expected in fiscal year 1984, and not in fiscal year 1985 as HCFA now contends.

A key document which is not mentioned in the HCFA review guide is a memorandum from the Director of Health Standards and Quality Bureau (the HCFA unit responsible for survey and certification activities). In this memorandum which was sent to all 10 HCFA regions on January 27, 1983, the Director makes four key points:

... Congress intends that all long-term care facilities be surveyed annually in accordance with Federal regulations.

... Funding is now at a level to support annual surveys of all long-term care facilities.

... It is incumbent on HCFA to move toward stricter compliance with Federal regulations.

... A liberal phase-in period would be expected under the circumstances.

Over 18 months after writing the January 1983 memorandum, the Director in another memorandum dated August 9, 1984, reaffirmed the Congressional intent and the commitment of the Administration to enforce the annual survey requirement. The Director stated that he would "expect that by this time we would be in full compliance with all provisions".

We agree with the Director. It is reasonable to expect that an eight month phase-in period (January 27, 1983 to September 30,1983) would be sufficient time for States to plan their survey and certification activities in such a way as to achieve full compliance with Federal regulations in fiscal year 1984. It is also reasonable for Congress to expect the Department to enforce its regulations particularly in light of enactments temporarily barring any changes in these regulations and of the Department's decision not to promulgate a final revised rule after the Congressional barriers expired.

Conclusions and Recommendations

HCFA's contention that MMACS was required to fill an increasing need for a centralized data base is even more valid today than it was at the time MMACS was established. A centralized data base containing such a wide array of survey and certification information should be an ideal foundation on which HCFA could plan national strategies for monitoring long-term care facilities.

Such strategies could include identification of all long-term care facilities that have not been surveyed within regulated timeframes. HCFA could then use its limited staff resources to home in on those States with the greatest problems; to require immediate surveys to protect the health and safety of Medicare and Medicaid patients, and to impose fiscal disallowances as a deterrent against repeated occurrences.

Other, more imaginative uses could be made of MMACS to help HCFA meet new challenges arising from authorities granted by the Omnibus Reconciliation Act of 1980. This Act authorized HCFA to take direct action against long-term care facilities based on its own surveys. The Act also authorized HCFA to impose an intermediate fiscal sanction -- denying reimbursements for new admissions for a period of up to 11 months -- against facilities no longer meeting one of more of the conditions or standards for program participation.

In a draft audit report (ACN 03-60155) dated November 12, 1985, we commented on HCFA's authority to impose an intermediate fiscal sanction. We recommended that final regulations and instructions be issued as soon as possible after giving consideration to certain changes that we had suggested. We also recommended that MMACS be used as the key management tool for identifying long-term care facilities that should be earmarked for intermediate sanctions and pointed out how MMACS data can be used to make these identifications.

HCFA can use MMACS in this fashion, however, only if it ensures that MMACS data is as current and as reliable as possible. We believe this can be accomplished not only by encouraging timely input of information into the system but also requiring use of the system's output as the basis for monitoring of State survey and certification activities.

We, therefore, recommend that HCFA:

1. Rescind its review guide requiring each region to review one State. In its place a national strategy should be developed for monitoring long-term care facilities using MMACS as the basis for management decisions. In developing this strategy, the following steps should be performed:

   a. Require regions to enter onto MMACS all available survey information so that the data is as current as possible.

   b. Once MMACS is updated, use it to identify all long-term care facilities that have not been surveyed within regulatory timeframes.

   c. Using this information, HCFA should identify the States where reviews should be conducted.

   d. Every long-term care facility identified as being out of compliance by the review should be subjected to a fiscal disallowance beginning in fiscal year 1984 if the non-compliance began during that year.

   e. Use MMACS as the primary management tool for developing strategies to implement its inspection and intermediate sanction authorities granted by the Omnibus Reconciliation Act of 1980.

2. Take steps to ensure that the MMACS data base is kept as current as possible. These steps should include:

   a. Enforcing the 45 day timeframe that States have to forward survey results to regional offices. Technical assistance may be required to bring recalcitrant States up to standard.

b. Establishing and enforcing a timeframe for HCFA regional offices to input survey results onto MMACS after receipt from State Survey Agencies.

3. Following a similar rationale, HCFA should re-examine the use of MMACS in monitoring survey and certification activities related to medical facilities other than long-term care facilities. Improvement should be made as appropriate.

EXHIBITS

Exhibit 1

Summary of OIG Survey Results

Region	States	Facilities: Out of Compliance Per MM[illegible]	Facilities: Total Reviewed	Facilities: MMACS Incorrect	Facilities: Out of Compliance
I	Massachusetts	244	232	232	
	Connecticut	77	77	60	17
II	New York	439	439	439	
	New Jersey	205	205	205	
III	Pennsylvania	107	70	67	3
IV	Florida	56	56	56	
	South Carolina	41	41	41	
V.	Illinois	184	62	55	7
	Michigan	250	55	55	
	Ohio	216	60	57	3
VI	Texas	335	24	24	
	Arkansas	151	24	24	
IX	California	141	141	141	
X	Oregon	82	82	50	32
		2528	1568	1506	62

Exhibit 2
Page 1 of 2

Comparison of MMACS Applications

	Number of Facilities Out of Compliance (Per MMACS) in January 1985	Number of Facilities Out of Compliance (Per MMACS) in October 1985	Difference
Region I			
Connecticut	77	138	61
Maine	45	30	-15
Massachusetts	244	258	14
New Hampshire	29	7	-22
Rhode Island	26	110	84
Vermont	19	10	-9
Region II			
New York	439	640	201
New Jersey	205	200	-5
Region III			
Delaware	3	12	9
Washington, DC	4	11	7
Maryland	27	41	14
Pennsylvania	107	240	133
Virginia	24	45	21
West Virginia	25	6	-19
Region IV			
Alabama	15	3	-12
Florida	56	36	-20
Georgia	33	9	-24
Kentucky	22	22	-
Mississippi	8	12	4
North Carolina	12	7	-5
South Carolina	41	5	-36
Tennessee	28	4	-24
Region V			
Illinois	184	165	-19
Indiana	297	26[illegible]	-28
Michigan	250	222	-28
Minnesota	113	112	- 1
Ohio	216	195	-21
Wisconsin	102	48	-54

Exhibit 2
Page 2 of 2

	Number of Facilities Out of Compliance (Per MMACS) in January 1985	Number of Facilities Out of Compliance (Per MMACS) in October 1985	Differenc
Region VI			
Arkansas	151	52	-99
Louisiana	37	77	40
New Mexico	26	18	- 8
Oklahoma	40	38	- 2
Texas	335	258	-77
Region VII			
Iowa	61	33	-28
Kansas	53	24	-29
Missouri	102	54	-48
Nebraska	22	17	- 5
Region VIII			
Colorado	25	20	- 5
Montana	10	10	-
North Dakota	5	7	2
South Dakota	19	3	-16
Utah	5	1	- 4
Wyoming	2	2	-
Region IX			
Arizona	1	3	2
California	141	202	61
Hawaii	7	11	4
Nevada	7	5	- 2
Region X			
Alaska	4	3	- 1
Idaho	15	13	- 2
Oregon	82	106	24
Washington	48	28	-20
	3,849	3,842	

[COMMITTEE STAFF NOTE: This Request for Services changes the list of regulatory requirements identified by HCFA as "Critical Requirements" (CRs).]

REQUEST FOR SERVICES

1. TO
Charlie O'Neill, Chief, BDMS/OHPB/DPMS

2. REQUESTED BY Michael Moran, Chief, HSQB/OSC/DDPA/DMB	3. DATE OF REQUEST 2/18/86

4. LIAISON REPRESENTATIVE CG Carol Gorschboth, BS Barb Slobodin, DG Dennis Glover	5. EXTENSION 43432 47942, 43438	6. REQ. COMPLETION DATE 5/15/86

7. SUBJECT OF REQUEST
PaCS Programming Specifications

8. DESCRIPTION/JUSTIFICATION OF REQUEST

SEE ATTACHED

☒ ATTACHMENT

EVALUATION BY SERVICING ORGANIZATION

9. PROJECT TITLE		10. PROJECT NUMBER
11. PROJECT MANAGER	12. EXTENSION	13. LEAD COMPONENT
14 ☐ APPROVED ☐ APPROVED DEFERRED	☐ REJECTED	15. COMMITMENT DATE

IF **NOT** APPROVED, REASON FOR REJECTION

16. APPROVING OFFICER

FORM **SSA-3893** (3-78) (FORMERLY CO-2004) PRIOR EDITIONS USABLE UNTIL EXHAUSTED

SKILLED NURSING FACILITIES (L007=02, 03, 04) Provider Group 2

I 4

CRs Data Tag	Description
F62	Residents Manage Own Financial Affairs
F63	Complete Accounting on Resident Funds
F64	Facility does not Commingle Resident Funds
F65	Written Delegation of Resident Funds
F69	Financial Record Readily Available
F70	Free From Mental and Physical Abuse
F71	Authorized Use of Restraints
F72	Restraints Used in Emergency
F73	Use of Restraints Authorized by Staff
F96	SNF Resident Supervision by Physician
F97	ICF Resident Supervision by Physician
F109	Emergency Services
F110	Physician Availability for Emergency Care
F112	ICF Nursing Services
F113	24-Hour Nursing Service
F127	Sufficient Nursing Staff
F132	Qualified Full Time Nurse
F155	Rehabilitative Nursing Care
F156	Resident Receives Rehabilitative Care
F157	Evaluation of Needs
F166	SNF Administration of Drugs
F172	SNF Conformance with Physician Drug Orders
F174	Drugs Administered According to Orders
F176	SNF Menus and Nutritional Adequacy
F178	Menus Meet Nutritional Needs of Residents
F180	ICF Therapeutic Diets
F181	Prescribed Therapeutic Diets
F182	Therapeutic Menus
F192	ICF Frequency of Meetings
F193	Three Meals A Day
F218	Provision of Services
F239	Written Patient Care Plan
F265	SNF Patient Transfer
F267	Transfer to Another Facility
F268	Interchange of Information
F273	Communications System
F288	Resident Call System
F308	ICF Facilities for Special Care

Revised 2/07/86

T S

SKILLED NURSING FACILITIES (L007=02, 03, 04) Provider Group 2

CRs

Data Tag	Description
F309	Special Rooming Provisions
F310	Precautionary Signs
F325	ICF Dietetic Service Area
F331	Sanitary Storage and Preparation
F336	Emergency Generator for Life Support System
F338	Aseptic and Isolation Techniques
F349	SNF Disaster Plan
F350	ICF Disaster Plan
F355	Drills
F357	Orientation and Training
F501	SNF Licensure
F503	Current State License
F515	Disclosure of Ownership
F521	Independent Medical Review
F528	Institutional Planning
F529	Overall Plan, and Budget
F530	Budget Reviewed, Updated Annually
F531	Capital Expenditures Plan
F566	Residents Manage Own Financial Affairs
F567	Facility Maintains Complete Accounting System
F568	Facility Does Not Commingle Resident Funds
F569	Resident Request for Assistance is in Writing
F572	Financial Record Available to Resident
F573	Resident Free From Mental, Physical Abuse
F574	Restraints-Used Only When Authorized by Physician
F575	Emergency Restraints Used to Protect Resident From Injury
F576	Emergency Restraints Authorized by Professional Staff Member
F592	Resident Care Policies
F593	Policies Govern Care and Related Services
F596	Policies Developed by Professional Personnel
F598	Responsibility for Policy Execution

Revised 2/07/86

Skilled Nursing Facilities (L007 - 02, 03, 04)

Provider Group 2

CRs

Data Tag	Description
F633	SNF Physician Supervision
F634	ICF Physician Supervision
F637	Emergency Services
F639	Facility Provides Nursing Care as Needed
F640	Director of Nursing Services
F641	Director is Qualified RN
F645	RN, LPN, or LVN Supervisor 7 Days on Day Shift
F646	Nurse Has Current State License
F653	SNF Twenty-Four House Nursing Service
F654	ICF Twenty-Four House Nursing Service
F655	Policies Address Total Nursing Needs
F666	Rehabilitative Nursing Care
F670	Administration of Drugs
F672	SNF Conformance With Physicians' Drug Orders
F696	Special Diets Planned by Qualified Dietitian
F701	Sanitary Conditions
F719	Control and Accountability
F728	Provision of Services
F732	Blood and Blood Products
F784	Resident Transfer
F785	Transfer of Residents Between Hospital and SNF
F786	Interchange of Information
F787	Security of Personal Effects
F796	Aseptic and Isolation Techniques
F806	ICF Disaster Plan
F807	Written Plan for Emergencies
F808	Disaster Plan Rehearsal
F813	SNF Disaster Plan
F821	Orientation and Ongoing Training

Revised 2/07/86

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

2068

Memorandum

Date FEB 19 1986

From Richard P. Kusserow Bryan Mitchell
For Inspector General

Subject OIG Draft Audit Report - Expanding The Swing-Bed Provisions Of The Omnibus Reconciliation Act of 1980 - Audit Control Number 03-60221

To

Henry R. Desmarais, M.D.
Acting Administrator
Health Care Financing Administration

Attached for your review and comments is a draft audit report on the results of our review of the swing-bed provisions of the Omnibus Reconciliation Act of 1980. These provisions allow small rural hospitals to use excessive beds to provide Medicare and Medicaid patients with long-term nursing care, depending on their specified needs. The provisions have been in effect now for about 5 years and have proven successful. Swing-beds enable Medicare and/or Medicaid patients to gain immediate access to needed long-term care that otherwise may be denied them due to nursing home bed shortages.

We believe HCFA should expand the swing-bed provisions to acute care hospitals, regardless of location or size. Certainly the conditions in rural areas which prompted HCFA to initially support swing-beds exist in urban areas as well. Excess hospital beds number in the thousands while there is a critical shortage of nursing home beds. Expanding the swing-bed provisions will help thousands of the nation's elderly and poor obtain nursing home care. It may also help to reduce future capital construction costs by $3.7 billion. Medicare and Medicaid especially could share in about $1.9 billion of the potential cost savings.

Because use of swing-beds is vulnerable to abuse by participating hospitals and because there is some concern that full expansion could overtax existing control systems, we are recommending that HCFA expand the use of swing-beds to selected large urban hospitals as suggested by the University of Colorado's Center for Health Services Research under a HCFA contract. This experiment should be the basis for any subsequent legislation proposed by HCFA to expand the swing-bed provisions to all acute care hospitals.

If you or your staff wish to discuss the material contained in this draft report, please let me know or contact F. J. Majka, Assistant Inspector General for Audit. We would appreciate receiving your comments within 30 days from the date of this memorandum.

Attachments

DRAFT

EXPANDING THE SWING-BED PROVISIONS OF THE OMNIBUS RECONCILIATION Act of 1980

DEPARTMENT OF HEALTH & HUMAN SERVICES-USA

NOTICE

"This draft of a proposed Office of Audit report is being made available for review and comment by officials having management responsibilities concerning the matters presented. This draft report is not to be considered final as it is subject to further review and revision. Please adequately safeguard this document against unauthorized use."

OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDIT

Audit Control Number 03-60221

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EXECUTIVE SUMMARY

Under the swing-bed provisions of the Omnibus Reconciliation Act of 1980, Congress granted small, rural hospitals the option of using a number of acute care beds to provide Medicare and Medicaid patients with long-term nursing home care, depending on their specific needs. As envisioned by Congress, the swing-bed provisions benefitted both hospitals and patients. Hospitals were able to effectively utilize large numbers of excess beds -- a problem largely resulting from public and private cost containment efforts. Patients were able to gain immediate access to needed nursing care which otherwise might have been denied them due to nursing home bed shortages -- a problem largely resulting from the aging of our population and restrictions on nursing home construction.

In our opinion, the swing-bed provisions have proven to be successful in delivering care to the nation's poor and elderly, and, HCFA should consider expanding the swing-bed provisions to acute care hospitals regardless of their location or size. Clearly the need for such nationwide expansion exists as thousands of hospital beds lie empty while thousands of our elderly and poor face great difficulty in gaining immediate access to nursing home care.

For example, in Chapter 2 we point out that excess hospital beds are a nationwide problem and not a phenomena restricted to rural locations. Current estimates of the number of excess hospital beds range from 69,000 to 264,000. Our estimate based on health planning regulations issued by the Public Health Service (PHS) places the number at 148,500 excess beds in 1983. None of the estimates take into account the effect of the prospective payment system (PPS) for hospitals caring for Medicare patients. Health experts generally agree that PPS will result in even more excess beds in the future.

In Chapter 3 we address the shortage of nursing home beds. This too is a nationwide problem. Some leading experts predict that by 1990 there will be a need for more than one-half million additional nursing home beds. This shortage impacts greatly on Medicaid and Medicare patients whose costs of long-term care comprise over 50 percent of our nation's nursing home expenditures.

In Chapter 4 we point out that the benefits to be derived from expanding use of swing-beds to urban hospitals will be similar to benefits already demonstrated in rural hospitals, but on a much wider scale.

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The most direct and immediate impact of allowing urban hospitals the option of using swing-beds will be felt by the nation's poor and elderly who are dependent upon Medicare and/or Medicaid for needed health care. Conversion of empty hospital beds to swing-beds will enable many of these people to gain immediate access to long-term care and thus, spare them the trauma associated with what health care professionals term the "no care zone"; a term used to describe the plight of Medicare and Medicaid patients released from hospitals without prospects of either adequate in-home care or nursing home care.

Congressional studies show that hospitals are releasing patients "quicker and sicker" and generally attribute this trend to Medicare's PPS. Allowing hospitals to provide long-term care in swing-beds when there is a demonstrated need for such care will help alleviate some of the pressure on hospitals for early discharges and will result in better care for patients.

Patients, however, will not be the only ones to benefit from expanding the use of swing-beds. Hospitals will benefit in that they will be better able to effectively utilize an estimated 148,500 excess beds that cost about $12.3 billion to build and about $5.3 billion annually to maintain. The nation's economy will benefit in that it may be able to avoid financing construction of thousands of nursing home beds due to hospital swing-beds being used in their stead. Based on our estimate of excess beds, the savings in construction costs could reach $3.7 billion.

Finally, Medicare and Medicaid will benefit in two ways. One, the programs will be better able to serve their clients without offering a new and expensive service -- it should be emphasized that Medicare and Medicaid patients are already entitled to long-term care as long as they can demonstrate a medical need for such care in accordance with program regulations. Two, the programs, especially Medicaid, will share in the potential cost savings attributable to avoided construction of nursing homes. Based on the programs' share of the nursing home market and the number of beds that may no longer be needed, we estimate Medicare and Medicaid's share of this potential cost savings to be about $1.9 billion.

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A preliminary study on the use of swing-beds, prepared under a HCFA contract also reported favorably on the use of swing-beds and recommended that HCFA expand usage on an experimental basis. The consensus of opinion was that use of swing-beds can help satisfy a need for long-term care, a need that will likely intensify in the future.

This need, however, has to be weighed against potential abuses that may arise from use of swing-beds. There exists the possibility that hospitals could abuse the swing-bed program through premature hospital discharges to swing-beds or through provisions of unneeded ancillary services. To combat this potential abuse, HCFA already has an on-going network of utilization controls involving Professional Review Organizations (PROs), Medicare intermediaries and carriers and Medicaid state agencies. Use of swing-beds was added to their monitoring responsibilities. We recognize, however, that these controls depend on the operational effectiveness of the groups involved and the amount of Federal funds available for control purposes. HCFA expects that review of swing-bed usage will decline sharply due to the uncertainty of future budget allocations.

Because there is such a need for nursing home beds and because HCFA has at least some controls in place over the use of swing-beds, we believe that HCFA should begin immediately to expand the use of swing-beds to urban hospitals. Perhaps the most prudent approach is the expansion through experimentation approach recommended in the preliminary study mentioned above. The Department has the authority to begin this experimentation immediately and, in our opinion, HCFA should have the information needed to start immediately.

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CHAPTER 1
SMALL RURAL HOSPITALS USE SWING-BEDS

In 1973, the first swing-bed program began in Utah as an experimental demonstration program funded by the Department of Health and Human Services. Under this experiment, hospitals were permitted to use beds to provide either acute hospital care or long-term care depending on specific medical needs of patients, hence the term swing-bed. The purpose of this initial experiment was to determine whether the use of hospital swing-beds would assist in satisfying the demand for long-term care in rural communities and improve the stability of rural hospitals. In 1976 and 1977, three additional swing-bed experiments were initiated in Texas, South Dakota and Iowa to further investigate the advantages and disadvantages of hospital swing-beds in rural communities.

In total, 108 hospitals participated in the four state experiments. At the time, the experiments contained two unique features previously not considered in the existing Medicare and Medicaid regulatory mechanisms, namely, participating rural hospitals were permitted to provide long-term care without meeting all the conditions of participation normally required for reimbursement and the swing-bed experiments changed Medicare reimbursement for routine long-term care to a per diem payment. The per diem reimbursement also included incentive payments to participate in the swing-bed program. Reimbursement for swing-bed related ancillaries was handled in accordance with normal Medicare reimbursement policies in place before the Prospective Payment System (PPS).

Medicaid reimbursement for swing-bed care during the experimental stages consisted of per diem payments for skilled and intermediate care. Unlike Medicare, however, Medicaid reimbursement did not include incentive payments, while ancillary reimbursement was handled in accordance with standard Medicaid policies.

The results of the swing-bed experiments were provided to HCFA in 1980. The major conclusions drawn during the experiments were:

... It was appropriate to implement a national swing-bed program in rural areas.

... A swing-bed program would benefit rural communities in terms of meeting both long-term and acute care needs.

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... Assuming reimbursement is flexible and based upon the concept of incremental cost of care, the swing-bed approach is a cost-effective means of providing long-term care.

Congress Implements Swing-Bed Provisions

The favorable results of the swing-bed experiments led to the enactment of the swing-bed legislation. Congress enacted Section 904 of Public Law 96-499 - the Omnibus Reconciliation Act of 1980 - commonly known as the swing-bed provisions, to address the shortage of nursing home beds in rural areas for Medicare and Medicaid beneficiaries. Under these provisions, small rural hospitals, defined in the Law as those with fewer than 50 beds, would be reimbursed under either Medicare or Medicaid for furnishing long-term nursing services to Medicare or Medicaid beneficiaries. By allowing the use of hospital beds in this manner, Congress provided eligible hospitals greater flexibility in meeting the demands for inpatient hospital and nursing home care.

Under the swing-bed provisions, hospitals wishing to participate in the program must first obtain a certificate of need for the provision of skilled and intermediate care services from the state health planning and development agency. Further, the Law provides that:

... Participating hospitals must meet the discharge planning and social services standards applicable to Skilled nursing facilities participating in the Medicare and Medicaid programs.

... Medicare skilled care type services in swing-bed hospitals are subject to the same eligibility and coverage requirements as services furnished by participating skilled nursing facilities.

... Payments for swing-bed services be made at the average rate per patient day paid for skilled and intermediate routine services, respectively, during the previous calendar year under the State's Medicaid plan.

... Reimbursement for ancillary services will remain on the basis of reasonable costs.

... Hospitals having 24-hour nursing coverage waivers are not eligible to participate as swing-bed hospitals.

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As can be seen, Congress attempted to strike a balance between swing-bed hospital care and nursing home care to assure the quality of care for long-term care patients. It is also clear that in authorizing the swing-bed provisions, Congress intended to utilize the excess beds in rural hospitals to increase the supply of long-term care beds. Thus, the swing-bed requirements have been kept to a minimum and contain the flexibility necessary to assure compliance.

Under the Law, skilled services in a swing-bed hospital are subject to the same Medicare coverage requirements and coinsurance provisions that are applicable for skilled nursing facilities. Skilled care days in swing-bed hospitals are to be counted against total skilled care benefit days available to Medicare beneficiaries. Other existing Medicare program requirements are applicable to skilled care services in swing-bed hospitals, namely:

... Medicare beneficiaries receiving a skilled level of care in a swing-bed hospital must first meet the 3-day prior hospital stay requirement before being transferred to skilled nursing care.

... Beneficiaries must also meet the requirement for "timely transfer" to a skilled nursing facility. That is, they must need and receive a covered level of skilled care within 30 days after "discharge" from hospital care.

Under the Medicaid program, skilled and intermediate services can be covered in a swing-bed hospital only to the extent that such services are covered in the state's Medicaid plan. As with the Medicare provisions, the swing-bed legislation made no changes in statutory provisions governing skilled and intermediate services, other than to permit payment by the state when services are furnished in a swing-bed setting.

The swing-bed provisions established a new method of reimbursement for routine services furnished in the hospital setting to Medicare patients who require skilled care and for determining the reasonable costs of routine services furnished to inpatients who require hospital care. Medicare reimbursement for ancillary services used by swing-bed patients is to be computed in the same manner as is done for ancillary services received by regular hospital inpatients. Reimbursement for furnishing general routine skilled care services to Medicare beneficiaries in swing-beds is limited to the average rate per patient day paid for routine skilled care services during the previous calendar year under the Medicaid program.

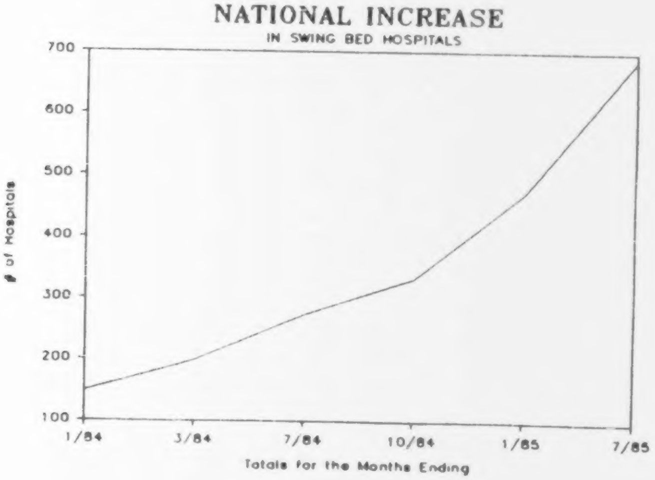
The Medicaid reimbursement provisions for swing-bed services are comparable to those for Medicare. Specifically:

... Swing-bed hospitals will be paid for skilled and intermediate routine services at the statewide average rates paid under the state plan during the previous calendar year to skilled nursing facilities and intermediate care facilities as appropriate.

... The reasonable costs of ancillary services will be determined in the same way for hospitals.

Use Of Swing-Beds Currently On The Rise

The enactment of the swing-bed regulations gave an estimated 1,350 rural hospitals with fewer than 50 beds the opportunity to provide nursing home services to Medicare and Medicaid beneficiaries. Starting with the 108 hospitals in the original swing-bed experiments, the number of rural hospitals embracing the swing-bed program has steadily risen to the current high of 688 in July of 1985. As illustrated below the most dramatic increase occurred during the 1984-85 period -- 361 percent --when PPS was implemented.



Aside from the number of hospitals involved, another indication of acceptance is the positive attitude of state licensing and certification officials who were originally skeptical of swing-beds. The state of Mississippi is a good example of this changing attitude. With only four Medicare certified nursing facilities in the entire state, the swing-bed program was originally opposed by state health officials. However, little by little this opinion changed. The Mississippi state licensing and certification agency, through close monitoring of swing-bed stays, has found that the program has produced quality care for those patients placed in swing-beds. It is the opinion of officials from the state licensing and certification agency that:

... Appropriate levels of care are provided to swing-bed patients.

... The rehabilitation potential of patients in swing-beds is realized earlier and faster.

... Swing-bed patients become stabilized during their stays in swing-beds making them more attractive admission possibilities to nursing homes since they would require less care upon admittance.

... Swing-bed patients are often discharged home rather than to a nursing home.

Mississippi officials noted that no complaints were received from patients receiving swing-bed care regarding the quality of care rendered during their swing-bed stay. Further, the swing-bed stays averaged about 20 days in duration, considerably less than a nursing home stay.

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CHAPTER 2
EXCESS HOSPITAL BEDS

The cost of hospital care increased from $9.1 billion (about 34 percent of health are spending) in 1960 to $157.9 billion (about 41 percent of health care spending) in 1984. The number of community hospital beds also rose sharply (about 60 percent) as noted below:

Year	Community Hospital Beds (thousands)	U.S. Population (millions)	Number of Hospital Beds per 1,000 persons
1960	639	180.7	3.5
1970	848	204.8	4.1
1980	988	227.7	4.3
1983	1,018	235.0	4.3

This growth has had a major impact on the Medicare and Medicaid programs which in 1983 paid for about 37 percent of all hospital care. Medicare is particularly affected since about 30 million elderly are covered under its Hospital Insurance portion (Part A) and their per capita hospital expenditures are more than twice the per capita expenditures for persons aged 19 to 64.

In spite of this growth in both expenditures and beds, several studies made over the last 10 years indicate that thousands of hospital beds are excess to the needs of the population. Estimates of the number of excess beds range from about 69,000 to 264,000 and are based on methodology established under the Hill-Burton program, such as target number of beds per 1,000 persons in the general population or target occupancy rates.

Why Do Excess Hospital Beds Exist?

There are several reasons why excess hospital beds exist. Pressures in the medical community by businesses tired of steeply escalating hospital costs for their employees and increased cost consciousness among consumers have been contributing factors to declining hospital utilization. Perhaps the greatest factor, however, has been the implementation of the PPS for hospitals treating Medicare patients.

Prior to PPS, hospitals were reimbursed for what they spent caring for a patient regardless of the nature of the illness, extent of treatment or length of hospital stay. Under PPS, hospitals are paid a set fee for treating Medicare patients according to specific diagnosis related

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groups (these groups define the nature of patients' illnesses). Regardless of the extent of treatment or length of stay, if hospitals treat patients for less than the established fees, they keep the difference as a profit. If they do not, hospitals must absorb the loss. Obviously, it is in the best financial interest of hospitals to release patients as soon as their medical conditions permit.

Hospitals have reacted swiftly to the PPS. Occupancy rates, which measure the percentage of a hospital's beds that are filled at a given point and depend on the number of admissions at a hospital and the amount of time (length of stay) patients stay in the hospital, are one measure for determining excess beds. These rates have plummeted.

A 1984 survey made by the American Hospital Association (AHA) showed that hospital admissions fell by 3.7 percent and inpatient hospital days by 8.6 percent. Another study showed that the length of stay dropped an average of 2 days within a one year period. Overall, the nationwide hospital occupancy rates fell to 67.7 percent through the last nine months of 1984, the lowest level in nearly four decades. This compares to the minimum occupancy standard of 80 percent established in National Guidelines for Health Planning.

Significance Of The Problem Of Excess Beds

Reductions in hospital admissions, inpatient hospital days and occupancy rates are indicative of a national trend aimed at containing costs. How this trend effects the viability of hospitals or the number of hospital beds nationally is difficult to determine as evidenced by the wide variance in the estimates of excess beds.

Estimates of Excess Hospital Beds Nationwide[1/]

Group	Estimate
Ensminger (1975)	264,000
McClure (1976)	68,887
Institute of Medicine (1976)	83,217
National Health Planning Guidelines (1978)	131,110
HHS, Health Resources Administration	116,283
Congressional Budget Office (1979)	150,000
HHS	211,498
Schwartz and Joskow (1980)	75,000

[1/] U.S. General Accounting Office. Constraining National Health Care Expenditures -- Achieving Quality Care At An Affordable Cost. Washington, DC, September 30, 1985.

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In 1984, the Office of Inspector General made a survey[2] of excess hospital beds using the targeted goal of not more than 3.7 hospital beds per 1,000 people established in health planning regulations issued by PHS. We concluded that in 32 states and the District of Columbia there were about 138,477 excess beds (See Appendix). We do not know how much it cost the nation's economy to build these excess hospital beds, but at 1983 prices the cost would approximate $11.5 billion. We estimate that another $4.9 billion is needed annually to maintain these excess beds. The latter estimate was based on various experts' opinions that maintaining an empty bed cost between 40 and 75 percent of the cost of maintaining an occupied bed,or about $35,400 per empty bed.

Using the same methodology, we modified our previous study to reflect 1983 statistics and to include the entire country. We estimated that there were about 148,500 excess community hospital beds in 1983. Using 1983 prices, these beds cost about $12.3 billion to build and about $5.3 billion annually to maintain. Based on Medicare and Medicaid paying about 37 percent of all hospital costs, we estimate they shared $4.5 billion of the building costs and $2 billion of the maintenance costs.

It is important to note that all of the above estimates were made prior to the start of PPS. Most experts agree that PPS will result in lower hospital utilization and, therefore, more excess hospital beds. In this regard, the AHA reported that hospital admissions for Medicare eligible persons declined by 3.7 percent and 7.6 percent in the first and second quarters of 1985, respectively as compared to the same quarters of 1984.

Urban Hospitals Also Have Excess Beds

In terms of expanding the swing-bed concept to urban hospitals, it is important to note that excess hospital beds are not found only in rural communities. Statistics for 1983 show that for urban areas there were 4.5 hospital beds for every 1,000 residents. This overall statistic exceeded the PHS targeted goal of not more than 3.7 beds per 1,000 people. Based on the number of Americans living in urban areas (standard metropolitan statistical areas) which we obtained from statistics compiled by the U.S. Census Bureau, we estimate that this .8 percentage difference represents about 135,500 excess hospital beds.

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[2] Office of Inspector General. Effect of Excess Hospital Beds on Capital Reimbursement Under PPS. Washington, DC, September 26, 1985

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The five county area surrounding Philadelphia, Pennsylvania was especially hard-hit in terms of excess beds. The Delaware Valley Hospital Council (DVHC) reported that its 90 member hospitals suffered a sharp decline in occupancy rates, particularly since the implementation of Medicare's PPS.[3]

Preliminary data for 1985 indicate that the average occupancy rate will drop 10.3 percent -- 78.2 percent to 67.9 percent -- from the previous year. Early projections further indicate that only one-third of the member hospitals will have occupancy rates exceeding 70 percent which the DVHC considers a break-even point for hospitals. This decline in utilization takes on added significance when it is considered that historically Philadelphia and surrounding counties have outpaced the average national occupancy levels by between five and 10 percentage points.

The President of DVHC expects a leveling off of the decline in hospital occupancy rates. He stated, however, that "at the same time, I think it's highly unlikely it will ever go shooting back up to previous levels... It will never be the way it was before". It is estimated that among the 7,500 to 25,000 unneeded hospital beds in Pennsylvania, there are between 1,000 and 2,500 of them in the five county Philadelphia area.

Other examples of unneeded hospital beds in urban areas are:

... Baltimore, Maryland - the State Health Resources Planning Commission estimated there were between 800 and 1,150 unneeded beds in 1983 and projected the number would reach 2,600 by 1988.

... Denver, Colorado - the Governor announced that there were 2,000 empty hospital beds in 1983.

... Cleveland, Ohio - Blue Cross/Blue Shield of Northeast Ohio reported 2,300 unnecessary hospital beds in 1983. The city reportedly had 20 percent more hospital beds than the national urban average. The unnecessary beds cost $130 million a year.

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[3] Gaul, G. "Those Rooms of Empty Beds Are Making Hospitals Sick". Philadelphia Inquirer, October 28, 1984

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CHAPTER 3
SHORTAGES IN NURSING HOME BEDS

Nursing home care is the fastest growing component of health care expenditures. In 1960, costs of nursing home care totalled about $6.5 billion, or about 1.9 percent of total health care expenditures. Twenty-four years later, nursing home expenditures jumped to $32 billion or 8.3 percent of total expenditures. As might be expected, the number of nursing home facilities and beds have also increased significantly. For example, in 1961, there were 9,900 facilities and 208,479 beds. In 1982, there were 25,849 facilities and 1,642,067 beds --increases of 161 percent and 688 percent, respectively.

Medicaid has been tremendously affected by this growth as about 31 percent of its total expenditures are for nursing home care and it accounts for almost 50 percent of all nursing home expenditures. In terms of the number of recipients involved, Medicaid supports about 575,000 patients in skilled nursing facilities and about 800,000 patients in intermediate care facilities. Medicare, on the other hand, expends less than one percent of its total expenditures in nursing home care (program coverage policies are more restrictive than Medicaid) and accounts for about only 2 percent of all nursing home expenditures.

One might think that with the massive expansion of nursing home beds, a situation would be found similar to hospital beds where literally thousands of excess beds exist. Quite to the contrary, however, most experts agree that currently there are serious shortages of nursing home beds throughout the country -- estimates range into the hundreds of thousands -- and that this condition can be expected to worsen. It is significant to note that Medicare and Medicaid patients are most adversely affected by the bed shortages because of their numbers, the programs' reimbursement policies and, to a lesser extent, their need for constant nursing care.

Why Do Nursing Home Bed Shortages Exist?

The most obvious reason for the shortage of nursing home beds is that more Americans are living longer. In 1950, only 8 percent of our population were 65 years of age or older. In 1980, 11 percent of our people, about 25.5 million, were 65 or older. Today, our life expectancy is about 75 years of age and after reaching 65, it increases to 82. Moreover, the 85 and over population has more than doubled in the last 20 years to about 2.6 million people.

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As noted below, it is this segment of our population that is in most need of nursing care.

Rates of Nursing Home Care[4]

Age	Residents in Nursing Homes per 1,000 population	
	Male	Female
Under 45 years	.17	.15
45 to 54	1.10	1.27
55 to 64	2.99	3.47
65 to 74	11.34	13.12
75 to 84	40.81	70.98
85 and older	179.83	289.53

Health care experts predict that the numbers of elderly will continue to grow. There will be about 32 million elderly by 1990 and about 35 million by the year 2000. The number of people 85 and older will almost double to 5.1 million by 2000. Experts also project that about one-fifth of this group will be in a nursing home at any given time. Obviously, these trends place increasing stress on the supply of nursing home beds.

A second reason for the shortage of nursing home beds is that nursing home construction has not kept pace with increased demand brought about by the aging of our population. According to one leading expert in the long-term care field, demand for nursing home beds is growing at a rate of 3 percent a year while the supply of beds is growing at a rate of 1 percent annually. This is due, at least in part, to certificate of need (CON) requirements placed on nursing home operators by states attempting to regulate construction of new nursing homes. The primary intent of CON controls on nursing home bed supply is to limit Medicaid expenditures -- CON controls also indirectly constrain nursing home operators from expanding the Medicare bed supply as well -- and, in this regard, most states have restrictive CON policies. Nine states, in fact, have placed a moratorium on new nursing home construction.

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[4] Russell, L.B. *An Aging Population and the Use of Medical Care*. Medical care, Vol. 19, No. 6 (June 1981).

The Aging Health Policy Center[5] of the University of California, San Francisco in a study issued in January, 1985 summed the whole matter of nursing home construction up very well when it concluded that it does not seem likely that the nursing home bed supply will expand through encouraging construction of more facilities. According to the Center, the costs are too great, particularly for those states with ongoing fiscal problems.

A third, less direct but certainly more insidious reason for nursing home bed shortages is that many of the elderly nursing home residents do not receive the level of care appropriate to their needs. A 1978 report by the U.S. General Accounting Office (GAO) estimated that as many as 20 percent of patients in skilled nursing homes and 40 percent of patients in intermediate care homes received unnecessarily high levels of care. If this condition exists today, it can only exacerbate the overall problem of bed shortages. In this regard, the Office of Inspector General has begun a survey of level of care determinations for nursing home care under Medicare and Medicaid. A separate report will be issued to the HCFA Administrator in fiscal year 1986.

Significance Of The Problem Of Bed Shortages

The conflicting trends of an aging population and restrictions on nursing home construction have had a major impact on the number of available nursing home beds. Most homes are operating at or near full capacity which results in long waiting lists and patients either being kept in community hospitals or possibly, released without the prospect of adequate follow-up care and placed in what health professionals refer to as the "no-care zone".

Actual shortages can be measured in terms of either facilities or beds. The Congressional Budget Office in 1977 estimated that by 1983 the country would need 31,450 skilled and intermediate care facilities to keep pace with population growth and demand for services. By 1983, there were only about 20,829 facilities, a shortfall of 10,621 facilities over the estimated need.

In so far as bed shortages are concerned, one long-term care expert estimated that by 1990, there will be a need for 587,000 additional nursing home beds with an additional 603,000 beds needed in the following decade. Another estimate places the need at around 655,000 additional beds by 1990.

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[5] Harrington, C and Grant, L. Nursing Home Bed Supply, Access, and Quality of Care. University of California San Francisco, California, Aging Health Policy Center, January, 1985.

As we found with hospitals, nursing home bed shortages are widespread and exist in both rural and urban areas as noted.

... The University of Pittsburgh sponsored a study of long-term care in Allegheny County which takes in the City of Pittsburgh, the second largest city in the Commonwealth of Pennsylvania. In 1984, a representative of the University testified before the U.S. House of Representative's Subcommittee on Health and the Environment, Committee on Energy and Commerce. The representative stated that in spite of a good deal of recent construction, there was a need for 2,389 more skilled and intermediate care beds in 1985. Kane Hospital, which is one of the largest nursing facilities in the country, was cited as an example. This facility had a waiting list of about 300 people, all of whom are Medicaid or Medicaid/Medicare eligibles.

... The Northeastern New York Hospital Association reported that in June of 1984 that up to 10 percent of hospital beds in Northeastern New York were filled with elderly patients who had nowhere else to go. This situation was forcing hospitals to serve a growing number of people who need long-term nursing home care. It also hurt the taxpayers who had to pay more for Medicaid patients who had to stay in hospitals (an example cited was $324 per day in a hospital versus $88 per day in a nursing facility). Area nursing home administrators agreed that there was a shortage of nursing home beds and most reported long waiting lists for entry to their facilities.

... DVHC analyzed patient placement problems in the five-county Philadelphia area and reported serious problems, primarily because of a shortage in nursing home beds. The 1982 Health Systems Plan of Southeastern Pennsylvania showed a regional shortage of 1,301 nursing home beds with 1,200 of them in Philadelphia.

Perhaps the best method of measuring the effect of nursing home bed shortages on Medicare and Medicaid patients is to consider the number of days that patients remained unnecessarily in hospitals awaiting nursing home placements. The GAO [6] reported that in 1979, Medicare and Medicaid paid for between 1.0 million and 9.2 million days for inpatient hospital care when only skilled or intermediate nursing care was needed but a nursing home bed was unavailable. GAO estimated that these hospital back-up days, as they are referred to, represented between one and seven percent of all Medicare and Medicaid inpatient hospital days in 1979.

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[6] U.S. General Accounting Office. Potential Effects of a Proposed Amendment to Medicaid's Nursing Home Reimbursement Requirements. Washington, DC, October 15, 1979.

In a 1980 report to the Secretary[7] we summarized the results of our service delivery assessment of patients remaining in hospitals beyond their need for acute care while awaiting nursing care. We pointed out that back-up patients were primarily poor (only 27 percent of them were private pay patients), generally old, and least able to care for themselves. We also pointed out that because backed-up patients were highly dependent, they were the least likely candidates for alternative care in lieu of nursing home care.

In a January 1985 report to Congress[8] HCFA also discussed the problem of hospital back-up days. HCFA stated that the size and scope of hospital back-up is difficult to measure but offered two greatly divergent estimates. One estimate was based on a one day survey taken by Professional Standards Review Organizations (PSROs) in 1979 and 1980. The PSROs' survey concluded that hospital back-up days totalled between 1.9 and 7.2 million days a year.

The other estimate was based on an actuarial cost model for Federal long-term care programs developed by ICF, Incorporated under contract to HCFA. Depending on assumptions made about the supply of nursing home beds, the estimate of hospital back-up days for Medicare and Medicaid patients ranges from 697,000 days to slightly more than 1 million days in 1980. ICF also projected slight increases in the number of hospital back-up days by 1985 and major increases from 1985 to 1990 -- 1,000 percent increase in Medicare and 400 percent increase in Medicaid. In one of its scenarios, ICF assumed a nursing home bed supply increase of 3 percent per year after 1978 (HCFA believes this to be the most accurate of the five scenarios presented) and estimated the following:

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[7] Office of Inspector General Secretarial Report, Restricted Patient Admittance to Nursing Homes, An Assessment of Hospital Back Up. Washington, DC, September 1980.

[8] Health Care Financing Administration, Office of Policy Analysis. Report to Congress: Study Of The Skilled Nursing Facility Benefit Under Medicare. Washington, DC, January 1985

	1985 Hospital Back-Up Days	1985 Hospital Back-Up Costs	1990 Hospital Back-Up Days	1990 Hospital Back-Up Costs
Medicare	101,000	$ 14,790,000	1,129,000	$ 234,561
Medicaid	1,266,000	$170,290,000	6,650,000	$1,323,808
	1,367,000	$185,080,000	7,779,000	$1,558,369

One point of clarification concerning the above chart is needed. The ICF estimates assume that regardless of which program paid for initial hospital care, the costs of hospital back-up days used by patients requiring skilled nursing care as defined by Medicare will be paid by Medicare and that costs of back-up days used by patients requiring Medicaid skilled or intermediate care will be paid by Medicaid.

While this assumption is valid for estimating costs associated with the back-up days, the dollar amounts give the impression that few Medicare patients remain in hospitals awaiting availability of nursing care. This, however, is not the case. Because 90 percent of persons needing nursing care are over 65 years of age and covered by Medicare Part A, the vast majority of the 7.8 million hospital back-up days estimated by ICF for 1990 are associated with Medicare patients whose hospital stays are paid under Medicare Part A but whose nursing home care will be paid by Medicaid.

"No-Care Zone" Represents A Potential Danger To The Elderly

HCFA now believes that because of events subsequent to the ICF study -- primarily implementation of PPS - the Federal programs will not have to absorb the nearly $1.6 billion associated with the 1990 estimate of hospital back-up days. Under PPS, Medicare makes no additional payments for hospital back-up days until after a patient's length of stay has reached the outlier threshold point for the diagnosis related group. After this threshold has been reached, Medicare will make additional payments but at a rate lower than under the previous retrospective payment system. HCFA believes these costs will be relatively low.

The situation is similar with Medicaid. The Aging Health Policy Center,(see footnote 5) contended that most state Medicaid programs no longer recognize back-up days in hospitals, or pay only a limited rate for such days. It concluded that "if no payments are made for back-up days in hospitals, then hospitals have greater incentives to either place patients in nursing homes, or the community...".

We agree with both HCFA and the Center's conclusions. It is only reasonable and prudent to expect that hospitals will do everything possible to avoid absorbing up to $1.6 billion in hospital back-up day costs projected by 1990. But this natural tendency to reduce potential losses raises a very serious issue. What will happen to Medicare and Medicaid patients during the 7.8 billion days that were projected for them to remain in hospitals awaiting availability of nursing home beds? Have there been sufficient nursing homes constructed to absorb these 7.8 billion days? The answer is obviously no. Will hospitals permit patients to remain without reimbursement? Indications are that they will not. Will patients be discharged from hospitals without any assurances that needed nursing home care will be available? Indications are that they may.

Many health professionals as well as ourselves and other Government officials fear that hospital efforts to discharge patients quickly brought about by PPS have created a "no care zone" for the elderly and poor. Our concern is that patients are moved out of hospitals quicker and sicker without prospects of substitute quality care being provided. We first expressed our concern to HCFA as early as July 1983, that Medicare and its beneficiaries were vulnerable to abuse through medically inappropriate discharges. We reiterated our concern in a memorandum to HCFA dated October 23, 1984.

The Chairman of the House Select Committee on Aging addressed the issue of the "no-care zone" when he reported that recent hearings have clearly demonstrated that Medicare patients are being discharged from hospitals sooner and sicker and that these same beneficiaries are having great difficulty in getting the long term services they need. The Chairman aptly categorized this as being a classical "Catch 22 situation". The Chairman of the U.S. Senate's Special Committee on Aging also expressed concerns over premature discharges and reported that Federal investigators had found at least 3,500 cases in which sick patients were sent home or transferred without justification.

If, as has been charged, hospitals are prematurely discharging patients that require inpatient hospital care, it is very unlikely that patients who have been judged not to need acute care will be allowed to remain in hospitals awaiting availability of nursing home beds. Many of these patients likely face the probability of being discharged from hospitals without any prospects of obtaining the long term care that they need.

CHAPTER 4
EXPANDING THE SWING-BED OPTION

On one hand, we have shown that prior to implementing the PPS there was already a considerable excess in the nation's supply of hospital beds in both rural and urban areas, and that under PPS the excess is expected to grow. On the other hand, we have shown that there is a severe shortage of hundreds of thousands of nursing home beds and the greatest impact of this shortage is felt by Medicaid and Medicare patients. The combined effect of these two trends has given rise to fears that many of our nation's elderly and poor will enter into a "no-care zone".

We have also shown that the introduction of swing-beds in small rural hospitals has been successful. The concept is rapidly gaining acceptance within the rural hospital community and early skepticism expressed by some state officials responsible for licensing and certification of nursing homes is disappearing. The true value of swing-beds, however, is that their use has helped limit the adverse effects of the "no-care zone" on Medicare and Medicaid patients by providing them needed nursing home type care which otherwise would not have been readily available.

We believe that these same benefits could be achieved on a much wider scale if the swing-bed option was open to community hospitals regardless of their size or location. Properly controlled expansion would benefit the elderly and poor who depend on Medicare and/or Medicaid; the hospitals which could more effectively use their resources; the nation's economy which might otherwise have to finance thousands more nursing home beds; and the Medicare and Medicaid programs which could better serve their clients and share in the cost savings resulting from reduced nursing home construction.

A preliminary report prepared under a HCFA contract also concludes that swing-beds fill a need for long-term care and recommends that the swing-bed program be expanded on an experimental basis.

Medicare and Medicaid Patients Would Benefit

The most direct and immediate benefit of converting thousands of excess hospital beds to swing-beds will be felt by Medicare and/or Medicaid patients. Literally thousands of these patients would be able to gain immediate access to services that:

- ... are already included in the coverage policies of Medicare and/or Medicaid,
- ... patients are already entitled to in that their eligibility for Medicare and/or Medicaid has been established, and
- ... are needed as evidenced by appropriate medical documentation and review.

In terms of numbers alone, we estimate that at least 148,500 excess hospital beds (this number will likely rise due to influence of PPS on Medicare) could be made available to Medicare and Medicaid patients in need of long term care. Fortunately many of these beds are located in states where the need for nursing home beds is significant.

For example, one study completed in November 1981,[9] identified the states with the lowest number of skilled beds per thousand persons age 65 and over. Our review of excess hospital beds show that 7 of these 10 states have excess beds totalling 19,704 which could be used to supplement the number of skilled beds available.

State	Skilled Beds Per 1,000 Elderly	Rank	Excess Hospital Beds
Oklahoma	1.13	51	1,664
Iowa	1.87	50	4,518
Maine	2.68	48	346
Virginia	3.28	46	328
Louisiana	4.07	45	2,907
District of Columbia	4.48	44	2,376
Tennessee	5.99	43	7,565
			19,704

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[9] Feder, J. and Scanlon, W. Medicare and Medicaid Patients' Access to Skilled Nursing Facilities. The Urban Institute, November 1981.

Excess hospital beds are not only located where the need is now, they are located where the greatest future needs are as well. To illustrate, in the ICF study previously referred to, (see footnote 8) 10 of the 12 states that had the greatest future need for nursing home beds also had excess hospital beds ranging in numbers from 683 to 12,994. In total, these 10 states had 67,983 excess hospital beds that could be converted to swing-bed use (see Appendix).

Other Benefits From Swing-Bed Usage

Others, beside Medicare and Medicaid patients will benefit from use of swing-beds. Hospitals choosing to participate will be able to more effectively utilize excess beds. We estimate the total number of excess beds available for swing-bed use at 148,500 prior to implementation of Medicare's PPS and expect this number to grow because of its implementation. These beds cost about $12.3 billion to build and $5.3 billion annually to maintain at 1983 prices.

The nation's economy may also benefit in that swing-beds help reduce the overall capital investment required to meet future nursing home bed needs. For example, if the 148,500 excess hospital beds are used as swing-beds, there should be a need for 148,500 fewer nursing home beds. Assuming an average construction cost of $25,000 per nursing home bed (a figure many experts agree is reasonable), about $3.7 billion in construction cost may be avoided.

Medicare and Medicaid particularly, would share in about $1.9 billion of the potential cost savings due to avoided construction since these programs account for about 52 percent of all nursing home expenditures. This point was also brought out in the report to HCFA. However, we believe the programs would benefit in another way as well. They would be able to better serve their clientele by improving the effectiveness of existing resources rather than by creating new resources or establishing new programs.

Preliminary Contractor Report To HCFA Recommends Expansion Of Swing-Beds

In November 1985, subsequent to the completion of our audit, the Center for Health Services Research, University of Colorado Health Sciences Center, Denver, Colorado issued under a HCFA contract a preliminary report on the use of swing-beds. The preliminary report was in response to a Congressional requirement that the Department report its experiences with the swing-bed provisions. The original due date for the final report to Congress was December 5, 1983, but due to various circumstances the final report has not yet been issued.

The Center's preliminary report corroborated our position that expanding use of swing-beds should prove beneficial to all concerned. According to the report, the swing-bed approach was viewed by most as providing a valuable community service in rural areas. By increasing long-term care access, particularly for Medicare patients, swing-beds fill gaps in the continuum of care, thereby enhancing the integration of health care services. With regard to hospitals, most administrators felt that swing-beds met a community need for long-term care and provided better continuity of care. The Center reported that problems and difficulties experienced by the hospitals appeared to decline in importance over time as hospitals gained experience with the program.

The Center concluded that "it appears appropriate to give consideration to the use of swing-beds in larger hospitals and hospitals located in urban areas, if only on an experimental basis". The Secretary has the authority to conduct such experiments under the Omnibus Reconciliation Act of 1980.

The Center recommended that HCFA gear this experiment towards developing alternate reimbursement methods and methods to curb abuse of ancillary charges. The report expressed concern that the current reimbursement method -- payment based on Medicaid reimbursements -- may not be adequate to encourage hospitals to make swing-beds available to Medicare patients. A combined acute and long-term care (per case) payment or even a more direct capitation type of reimbursement was recommended for consideration.

The potential abuse of ancillary charges derives from the fact that ancillary reimbursement for swing-bed care is cost-based. The Center believed that this method of reimbursement appeared to provide perverse incentives for hospitals to maximize revenues through the provision of ancillary services. Curbing this abuse could be achieved by placing a limit on total reimbursement per day or by closer review of the appropriateness of ancillary services by PROs and/or claim reviewers.

Swing-Beds Are Vulnerable To Abuse

We agree with the Center's observations that swing-beds, like most other health care delivery systems, are vulnerable to abuse. The Center pointed out potential abuse associated with ancillary services. Another and perhaps a more serious abuse relates to premature discharges from acute care to swing-beds. By releasing patients early, hospitals could profit under PPS and receive additional reimbursement for use of swing-beds. Cases of such abuse have been identified and the few problem providers involved have been or are being considered for corrective action including decertification of swing-beds, denial of swing-bed admissions, termination from Medicare and civil/criminal penalties for flagrant abuse.

We also agree with the Center's observations that abuse could be curbed by close review. HCFA already has a network of controls to monitor provider utilization for all services, including swing-beds. Medicare intermediaries and carriers and Medicaid State agencies have had for years numerous oversight responsibilities for provider and recipient utilization review. The Tax Equity and Fiscal Responsibility Act of 1982 established the Utilization and Quality Control Peer Review Organization Program to further strengthen utilization review. Under current HCFA instructions, PRO's are required to perform 100 percent review of utilization of swing-beds to ensure that (1) hospital discharges to swing-beds were appropriate and (2) patients in swing-beds required nursing care in accordance with program regulations. These reviews identified the problem cases discussed above that have resulted or may result in sanctions against the providers involved. HCFA's instructions to PRO's were improved in August 1985 by specially defining inappropriate transfers of patients from PPS units of hospitals into swing-beds as a prohibited action, requiring denial of payment for the swing-bed admissions, possible sanctions, intensified review of 100 percent of discharges, and referral to HCFA or the Office of Inspector General, if a sanction is recommended.

We recognize, however, that the effectiveness of these controls depends to a great extent on the effectiveness of the PRO's, carriers and State agencies and the amount of Federal funds available for control purposes. In this regard, HCFA plans to reduce the level of PRO coverage of swing-bed utilization during fiscal year 1986 to 50 percent of discharges. Problem providers, however, would continue to receive 100 percent review.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

HCFA is primarily responsible for small, rural hospitals being able to convert empty acute care beds into swing-beds capable of providing long-term care to Medicare and Medicaid patients. HCFA (actually its predecessor) assumed a leadership role as far back as 1973 when it authorized and funded a swing-bed experimental project in a single State. Throughout the seventies, three other single State experiments were authorized and funded, and in 1980 HCFA's efforts resulted in Congress adopting the swing-bed provisions as part of the Omnibus Reconciliation Act of 1980.

Our review as well as the preliminary study prepared by Colorado University's Health Sciences Center concluded that there is a need for more swing-beds throughout most of the country. This need, however, must be measured against the potential abuse that could occur if the current swing-bed provisions are expanded to large, urban hospitals. Considering that HCFA has improving controls in place over potential swing-bed abuse, including a 50 percent level of review by the PRO's, and has had over 5 years experience with use of swing-beds in rural hospitals, we believe that HCFA should move immediately to expand the use of swing-beds.

Perhaps the most prudent approach to expansion is the expansion through the experimentation approach proposed by the Center. We believe that a relatively widescale experiment with swing-beds in selected urban areas particularly effected by nursing home bed shortages would help alleviate some of the access to long-term care problems faced by Medicare and Medicaid patients and, at the same time, allow HCFA to experiment with alternate reimbursement methods and control systems. The Department has the authority to experiment in this fashion and HCFA should have enough information on swing-bed usage to begin immediately. Considering the HCFA's original report date to Congress was over 2 years ago, the experiment should be designed to provide the desired information in as short a timeframe as possible.

We, therefore, recommend that HCFA:

1. Implement an experimental strategy to expand the use of swing-beds in selected hospitals located in urban areas. The strategy should:
    a. Result in a timely conclusion so that HCFA can make a final decision on the use of swing-beds.

b. Consider the factors identified in the Center's report as needing additional study. These factors include alternate reimbursement methods, cost containment approaches, etc.

c. Specifically consider methods to prevent and/or detect abuse related to premature hospital discharges to swing-beds.

2. Should use the results of this experimental project as the basis for its report to Congress and, if appropriate, for seeking legislation to revise the swing-bed provisions of the Omnibus Reconciliation Act of 1980 to include all acute care hospitals regardless of location or size.

Appendix

EXCESS HOSPITAL BEDS
AND ASSOCIATED COSTS
IDENTIFIED BY OFFICE OF INSPECTOR GENERAL

STATE	BEDS PER 1,000 POPULATION	EXCESS BEDS	CONSTRUCTION COST (IN MILLIONS)	ANNUAL COST TO MAINTAIN (IN MILLIONS)
Alabama	4.79	4,306	$ 357.4	$ 152.5
Arkansas	4.84	2,621	217.6	92.8
Florida*	4.61	9,504	788.8	336.5
Georgia*	4.15	2,553	211.9	90.4
Illinois*	4.84	12,994	1,078.5	460.1
Indiana	4.38	3,707	307.7	131.3
Iowa	5.26	4,518	375.0	160.0
Kansas	5.45	4,220	350.3	149.4
Kentucky	4.17	1,736	144.1	61.5
Louisiana	4.37	2,907	241.2	103.0
Maine	4.01	346	28.7	12.2
Massachusetts	4.39	3,987	331.0	141.2
Michigan	4.20	4,561	378.5	161.5
Minnesota	4.68	4,054	336.5	143.5
Mississippi	4.83	2,888	239.7	102.3
Missouri	5.34	8,108	673.0	287.1
Montana	4.12	336	28.0	12.0
Nebraska	5.22	2,414	200.3	85.5
New Jersey*	3.95	1,838	152.6	65.1
New York*	4.33	11,083	919.9	392.4
North Carolina*	3.81	683	56.7	24.2
North Dakota	5.67	1,319	109.5	46.7
Ohio*	4.61	9,821	815.2	348.0
Oklahoma	4.22	1,664	138.1	59.0
Pennsylvania*	4.64	11,157	926.0	395.0
South Dakota	5.08	953	79.1	33.8
Tennessee	5.33	7,565	628.0	267.8
Texas*	4.22	8,022	665.8	284.0
Virginia*	3.76	328	27.2	11.6
Vermont	3.76	30	2.5	1.1
Washington, DC	7.47	2,376	197.2	84.1
West Virginia	5.08	2,697	223.9	95.5
Wisconsin	4.37	3,180	263.9	112.6
Total		138,477	$11,493.6	$4,092.8

* Indicates those states with the greatest need for nursing home beds as projected by ICF, Inc. Arizona, California, and Florida are also projected as states in greatest need of nursing home beds.

REPORT ON THE NEW LONG-TERM CARE SURVEY PROCESS

(Formerly the Patient Care and Services-PaCS-Survey Process)

Health Care Financing Administration
Health Standards and Quality Bureau
Office of Survey and Certification

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INTRODUCTION

The Health Care Financing Administration (HCFA) was established in 1977 to combine health financing and quality assurance programs in a single agency. Within the Department of Health and Human Services (HHS), HCFA is the principal source of funding for long-term care services. The vast majority of these funds are used to pay for nursing home care in both skilled nursing facilities (SNFs) and intermediate care facilities (ICFs). Along with its financial role in the delivery of long-term care services, HCFA is also responsible for assuring the quality of these services by setting standards for care providers and, in conjunction with the States, enforcing those standards.

This report introduces a new process to be used by Federal and State nursing home surveyors in enforcing the regulatory standards. The new long-term care survey process is the result of years of Federal and State experimentation with alternative survey methodologies. It implements a major change in the traditional nursing home survey, a change that has been advocated by providers, consumers and surveyors themselves, i.e., the focusing of inspections on direct resident care and the outcomes of that care rather than on the structural elements underlying the care. Although the new survey process represents an advance over the traditional process, HCFA recognizes that further improvements to the new process are still desirable. HCFA is committed to a continuing dialogue with the other primary parties involved in the nursing home quality assurance system in order to both refine the new survey process and to more effectively coordinate the process with other aspects of the overall system.

The purpose of this report is to describe how the new long-term care survey process became a reality and what it is intended to accomplish. The report begins with an overview of the Federal quality assurance role and the circumstances that led to a new survey process. Chapter Two details the experimental State systems approved by HCFA to test new ways of surveying nursing homes. Chapters Three through Five cover the early development and testing of the new survey process and the extended evaluation and refinement efforts of 1985, followed in Chapter Six by a specific discussion of the new survey procedures and forms. The report concludes by describing the role of consumer advocates, the nursing home industry and the State survey agencies in developing the new process (Chapter Seven), looking at the new surveyor training program (Chapter Eight), and providing some insight into HCFA's plans for the ongoing evolution of the survey process (Chapter Nine).

CHAPTER ONE

BACKGROUND: THE FEDERAL QUALITY ASSURANCE ROLE

Although the Federal government has been involved in the development of quality standards for nursing home care since the late 1950's, the passage of Medicare and Medicaid in the Social Security Act Amendments of 1965 signaled the beginning of an active Federal enforcement role. With the enactment of Medicare and Medicaid, the Federal government moved from advisor to primary participant in the development and enforcement of nursing home care standards. Despite this increased Federal involvement, the nursing home inspection process has historically been viewed as a "haphazard, fragmented and generally inadequate" one. 1/ This section of the report presents a brief overview of the current inspection process, discusses some of its perceived problems and provides background on the events that fostered development of a revised survey process.

Description of the Federal Quality Assurance Process

Sections 1101, 1863 and 1905(c) of the Social Security Act authorize the Secretary of HHS to prescribe regulations that must be met for a facility to become a provider under the Medicare/Medicaid programs. Since 1966, nursing homes that provide care for Medicare/Medicaid beneficiaries have been required to meet Federal regulations for the health and safety of these residents. These regulations (42 CFR Part 405, Subpart K and 42 CFR Part 442, Subpart F) are enforced through an annual certification survey of each nursing home by the State survey agencies under contract with HHS. As amended in 1967, the Social Security Act (Sections 1902 (a)(26) and (31)) also requires States to perform an annual review of each Medicaid recipient in a long-term care facility to determine the appropriateness of the level of placement and the quality of the recipient's care and services. Regulatory requirements for this inspection of care (IoC) process are contained in 42 CFR Part 456, Subpart I. The two-pronged Federal process is supplemented by nursing home licensure requirements established and enforced on a individual State basis.

The Survey Process

The facility survey process is the means for determining whether nursing homes are compliance with Federal regulations and can be certified for participation in the Medicare and Medicaid programs. It consists of an annual on-site inspection by a team of State surveyors to assess compliance with applicable Federal regulations. Following each survey, the State Agency survey team provides the facility with a list of deficiencies that must be corrected in order to obtain or maintain certification. The nursing home must then develop an acceptable plan and timetable for the correction of all deficiency citations. In most cases, State surveyors then conduct follow-up visits to assure that corrective action is taken. A home that continues to fail to comply with Federal requirements is subject to decertification. This means that it can no longer receive Federal reimbursement for Medicare/Medicaid residents, although it may still serve private patients if State licensure is retained.

Although the State survey agencies conduct the certification surveys, HHS maintains oversight by performing independent Federal surveys of facilities recently inspected by the States and comparing results, as well as through annual field visits to examine State agency program management procedures. HHS has also developed the Medicare/Medicaid Automated Certification System (MMACS), which provides a ready data base on the individual and aggregate nursing home survey results from all the States. Finally, HHS provides the States with standardized survey forms and procedural guidelines to be used by all State surveyors in determining compliance with Federal requirements. The changes in this component of the survey and certification system are detailed in Chapter Six.

The IoC Process

As noted, the IoC review process is composed of two major functions: quality of care review and level of care review. Quality of care review is concerned with the appropriateness of care provided to meet the health needs of each Medicaid recipient. Level of care review determines the necessity and desirability of an individual's continued placement in the facility and the feasibility of meeting his or her health care needs through alternative institutional or noninstitutional settings. HHS has provided some guidance to State Medicaid Agencies for performing IoC reviews, but it has been much more limited than assistance under the survey program. Annual inspections must be conducted by review teams composed of physicians or RNs and other appropriate personnel, and the reviewers must have personal contact with each recipient and review each recipient's record. Federal oversight of IoC review is limited to assuring that States meet procedural requirements, with no concerted Federal monitoring of the effectiveness and efficiency of the individual State programs and no Federal enforcement role.

An idea that has generated a great deal of interest over the last few years is that of integrating the IoC review process with survey and certification reviews. Fifteen States now have integrated systems, which can be roughly defined as the use of one team to conduct a facility survey and an IoC review on the same visit and linking the findings. Both certification surveys and IoC reviews have the same overall purpose of insuring that appropriate care and services are provided to nursing home residents. Since the new survey process greatly emphasizes the review of individual resident care, thus increasing duplication between the two review programs, the issue of integration is likely to take on greater importance.

Problems with the Survey Process

During the advent of Federal long-term care standards and the accompanying quality assurance programs in the late 1960's, the prevailing school of thought was that health and safety standards should provide the framework for appropriate care to take place and that quality care would inevitably result. Under this approach, regulators were expected to measure compliance and base enforcement on a facility's "capacity" to provide acceptable care. As the Department of Health, Education and Welfare (DHEW) noted in a report to the Senate Special Committee on Aging, "Present regulations for survey and certification procedures only confirm whether or not the facility is capable of delivering the required services, not whether the facility has implemented them or whether quality care has actually been administered." 2/ In theory then, the survey process would focus on a facility's capacity to deliver good care while the IoC review would focus on the appropriateness and quality of care actually delivered. Not surprisingly, criticism of this system surfaced swiftly.

As early as 1970, the Senate Special Committee on Aging's Long-Term Care Subcommittee heard testimony that ". . . inspectors are more concerned with the physical plant and less with the quality of patient care", 3/ and variations of this criticism have continued unabated since that time. Another common criticism has been that the traditional survey process is overly reliant on written documentation, resulting in the proliferation of what has come to be known as "paper compliance". New York State's Moreland Act Commission summarized this problem in its landmark 1975 report on the regulation of nursing home care:

> "A 'deficiency' rating caused by the absence of such written material as general patient care, nursing, dietary or special rehabilitative plans or by the absence of written pharmaceutical procedures, while relatively easy for a surveyor to render and verify, in most instances is difficult to consider significant enough to merit imposition of meaningful penalties. Nonetheless, surveyors apparently devote a substantial portion of their time noting such deficiencies and demanding corrective action. And, of course, a 'paper' deficiency can be corrected with relative ease by 'paper' compliance." 4/

The report went on to note that fully 290 of 526 identified items on a SNF survey report form could be answered by a surveyor exclusively with reference to a facility's written plans, policies and records while only 30 items would require direct observation of patients. 5/ Moreover, the Commission presented statistical analyses indicating that there was no correlation between the overall results of surveys, concentrating supposedly on whether nursing homes had the "capacity" to render quality care, and the results of IoC reviews that were to directly assess patient care. 6/

The Federal government did take steps during the early 1970's to upgrade nursing home care, including the establishment of a Federal training program for State nursing home surveyors in 1971 and the creation in 1972 of the Office of Nursing Home Affairs to consolidate all Federal nursing home enforcement responsibilites. Also, in 1974, DHEW published new regulations that implemented unified performance standards for SNFs and ICFs. However, these changes did not succeed in ameliorating continuing widespread concerns over the reliability and validity of the nursing home survey process, a process that has undergone little substantive revision since its initiation.

The Search for a New Survey Process

Since 1977, both the newly formed Health Care Financing Administration (HCFA) and some of the individual State agencies responsible for inspecting nursing homes have been experimenting with different methods of assessing quality of care through modifications to the survey process. The specific concerns about the traditional survey that prompted the search for a modified long-term care survey process included:

- -- Undue emphasis on the structural and procedural characteristics of a facility;
- -- Failure to evaluate facility performance in terms of the actual delivery of services and the measurable effects of care on patient outcomes; and
- -- Inconsistency in surveyor findings due to varying State methodologies in conducting surveys as well as widely divergent individual surveyor interpretation of program requirements.

HCFA and the States agreed on the need for a survey process that could more directly relate certification decisions to the quality of care provided to individual nursing home residents. Beginning with the Wisconsin demonstration project in 1978, HCFA authorized a series of State demonstrations and experiments incorporating various modifications to the traditional survey process. Chapter Two of this report provides details on the objectives and methodology of each State's process. One shared element of all the demonstrations, however, was that the modified survey processes generally focused on the review of resident care while decreasing emphasis on the review of administrative policies and procedures. It has been demonstrated in many instances that positive survey findings resulting from a structurally based process are not always an accurate indicator of high quality care in a nursing home. Conversely, negative findings from a structurally-based process do not necessarily indicate that a nursing home is providing low quality care. This lack of a direct relationship between structural capability and actual quality of care tended to undermine the credibility of the total survey process.

By early 1983, preliminary results of the State demonstrations and experiments were providing evidence of the availability of viable alternatives to the traditional process. HCFA began development of a modified survey process that synthesized the best components of the State approaches while maintaining national applicability. The primary objectives in developing the new process were twofold:

- -- To increase reliability by providing a survey process and reporting form that would ensure greater uniformity in terms of review approach, documentation, and certification decisions; and
- -- To increase the validity of the survey process by emphasizing surveyor review of outcomes and provision of care rather than paper and structural review, thereby allowing more time for direct patient observations and interviews.

The result of this effort was the Patient Care and Services (PaCS) survey process, the direct forerunner of the process that is being implemented nationally in 1986.

Consensus for Change

As HCFA was in the process of reevaluating the traditional survey and certification system, other segments of the long-term care community began to play expanded role. Although there had long been a consensus among Congress, Federal and State agencies, consumer organizations and the nursing home industry that changes were needed in the survey process, there was not always agreement as to the nature of these changes. In May of 1982, for example, HCFA issued a proposed set of changes to its regulations governing survey and certification standards and procedures (42 CFR Part 405, Subpart S). These regulations had been in effect since 1970 with no substantive changes since 1973. Proposed changes in the regulations included such controversial items as reducing the required frequency of surveys and expanding the use of national accreditation organizations for facility certification purposes.

Release of the so-called Subpart S proposals elicited a very strong and largely negative response. Congress reacted by placing a six-month moratorium on any changes to the current nursing home regulations beginning in November, 1982, and eventually extended until August, 1983. Then, in April, 1983, the Nursing Home Standards Act of 1983 (P.L. 97-276) was introduced in Congress. The bill proposed to set up a National Commission on the Regulation of Nursing Homes under the National Academy of Sciences, which would conduct a study of the nursing home regulations and make recommendations for needed changes. During the study period, the bill would have required that the moratorium remain in effect on changes in the Subpart S regulations and the related conditions of participation.

Although the bill was not passed, HCFA agreed to sponsor a comprehensive study of the regulation of nursing homes by the Institute of Medicine (IoM) of the National Academy of Sciences. In conjunction with the IoM study, which was to focus on "basic issues and long-term policy alternatives," HCFA also agreed to consult with consumer advocacy groups, State survey agencies, and the nursing home industry to identify possible short-term measures to improve the nursing home survey and certification process. From May through December of 1983, HCFA organized a series of meetings with a workgroup composed of Federal, State, consumer and industry representatives in order to identify areas of consensus on such measures. These sessions came to be known as the Subpart S meetings.

The possibility of a modified nursing home survey process was not part of the original agenda for the Subpart S meetings but soon surfaced as an adjunct to discussions on extended survey cycles. On June 14, 1983, the six States that had implemented innovative survey approaches presented reports to the workgroup on their progress and available findings. During subsequent sessions, HCFA staff reported on its progress towards development of a new national survey process.

The last formal meeting of the Subpart S workgroup took place on December 13, 1983. By this meeting, a consensus had been identified among the divergent groups reconfirming the belief that the survey and certification process would be substantially improved if it focused on the actual quality and provision of resident care rather than on a facility's structural and procedural capability to provide quality care. All parties agreed that the observation and assessment of residents should be the primary basis for compliance decisions. The participating organizations expressed their unanimous support for the reforms embodied in the early version of the PaCS survey process and for the eventual implementation of a resident-based, outcome-oriented survey process on a national basis. With their support, HCFA began the extensive process of testing and refining PaCS, which has culminated in a new national nursing home survey process.

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2/ U.S. Senate Special Committee on Aging. A Report of the Special Committee on Aging: A Study on the Problem of the Aged and Aging." U.S. Government Printing Office, Washington D.C., 1974

3/ "Trends in Long-Term Care," Hearings by Subcommittee on Long-Term Care. August 1970, pg. 740.

4/ New York State Moreland Act Commission on Nursing Homes and Residential Facilities, Report 1: "Regulating Nursing Home Care: The Paper Tigers." Albany, N.Y., 1975, pg. 36.

5/ Ibid., pg. 11.

6/ New York State Moreland Act Commission on Nursing Homes and Residential Facilities, Summary Report: "Long-Term Care Regulation: Past Lapses, Future Prospects." Albany, N.Y., 1976, pg. 14.

CHAPTER TWO

STATE DEMONSTRATIONS AND EXPERIMENTS

Introduction

An integral aspect of our effort to develop an improved nursing home survey process was the Federally-approved State testing of innovative survey methodologies. Beginning with Wisconsin in 1978, six States developed and implemented modified survey forms and review processes that they felt could provide better measures of nursing home performance than the traditional survey. The State approaches shared the common objective of concentrating on the review of resident care and outcomes while eliminating unnecessary paper review. When the actual care was deemed satisfactory, most of the States considered it unnecessary to look in detail at the structure underlying the care process.

The State survey projects took two different forms, demonstrations and experiments. Alternative State survey demonstrations often involved the waiver of regulatory requirements and were authorized by HCFA's Office of Research and Demonstrations (ORD) for Wisconsin, Massachusetts and New York. The State experiments consisted of changes in the survey process within current regulations and were approved by HCFA's Health Standards and Quality Bureau (HSQB) for California, Washington and Iowa. Rhode Island was also approved to develop an experimental survey approach, which was eventually synthesized with the PaCS process prior to implementation by the State.

Most of the new survey approaches HCFA examined used forms with specific performance indicators directed at the care actually provided by a facility rather than the facility's capability to provide care. This same approach has been incorporated as the cornerstone of the new national survey process. In developing the new survey form, HCFA staff reviewed and categorized the patient care indicators used by the experimental States and then synthesized the appropiate indicators for national application. The individual State models governing the use of these indicators were also carefully reviewed prior to the initial development of a national model. Although the diversity of States in terms of sophistication, resources, and survey structure precluded adopting any of the experimental protocols on a national basis, selected elements of the State models were built into the new national survey process.

The rest of this section provides a brief overview of the objectives, approach and results of each of the approved demonstrations and experiments. Most of this information was drawn from the final evaluation reports submitted to HCFA on each of the individual State demonstrations and experiments. (Copies of these evaluations are available under the Freedom of Information Act upon request to the U.S. Department of Commerce, National Technical Information Service, Springfield, Virginia 22161.)

Wisconsin

Beginning in July 1978, and continuing until July 1982, ORD granted Wisconsin a waiver to demonstrate new methods for conducting nursing home surveys and IoC reviews. Under Wisconsin's Quality Assurance Project (QAP), facilities with a history of good compliance were eligible to receive screening surveys and IoC reviews of a sample of Medicaid recipients rather than the traditional 100 percent resident review. The primary objective of the demonstration was to increase the effectiveness of the facility survey and the resident IoC through the reallocation of existing resources. Wisconsin anticipated that the screening and sampling approach would allow surveyors to use their time more effectively and ultimately result in improved quality of resident care in nursing homes.

Process

Wisconsin has had an integrated survey and IoC review process since 1973, and the QAP initiated changes in both processes, beginning with the use of criteria to determine which facilities were eligible for a screening survey and/or a sampling IoC. Surveyors could elect to screen an average or better facility using 10 key quality criteria. The screening criteria were identified by a panel of long-term care experts to focus more directly on quality of care delivery and less on paperwork requirements. In nursing homes with poor compliance records and in homes where screening results suggested problems, surveyors would carry out either a traditonal full survey of the entire 1,547 State and Federal regulations or a partial survey pursuing specific problems identified by the screen. Surveys were conducted in approximately 2 days by Wisconsin's traditional four person team including a nurse, sanitarian, social worker and engineer, but QAP stressed a multi-disciplinary team approach, and the sharing of findings. (Prior to QAP, surveyors in each discipline did not routinely visit a facility at the same time.)

The resident assessment part of the QAP (IoC review) allowed surveyors to conduct an intensive review of a resident sample (initially 10, later 20 percent) rather than the Federally-mandated review of all Medicaid residents, again based on the facility's quality of care history. The intensive review consisted of a resident interview and/or examination, a record review, and staff interviews conducted by a team consisting of a nurse, social worker and physician when needed. The underlying assumption was that if a facility's system for providing adequate quality of care was functioning for a sample of residents, it was functioning for all residents. If the home failed the sample, the traditional 100 percent IoC review was triggered. QAP also stressed the explicit integration of survey and IoC findings in determining what citations should be issued.

Evaluation

Wisconsin Health Care Research, Inc. (WHCRI) conducted the formal evaluation of the Wisconsin demonstration project. Based on an experimental design which compared the QAP to Wisconsin's traditional methods, WHCRI found no evidence of either improvement or deterioration in quality of care in nursing homes under QAP methods, as measured by the number of cited deficiencies. There were no significant differences in terms of compliance with regulations, frequency of repeat problems and overall Medicaid reimbursement to nursing homes. WHCRI found that QAP surveyors could produce survey and IoC results using screening and sampling techniques that were comparable to results of traditional methods, with fewer total staff hours.

This time savings was consistent across nursing homes of all quality; there was no increase in time reallocation to poor quality homes. The evaluation did indicate that the QAP detected significantly more severe deficiencies and that deficiencies were more resident centered, while the old method tended to detect more deficiencies of documentation (54 percent of QAP deficiencies classified as resident centered, 32 percent under traditional survey).

Not surprisingly, the results of this first demonstration were not exactly what the State had anticipated. Although there was no evidence of surveyor time reallocation, the results clearly indicated that the potential existed for cost-effective changes in the traditional survey system without loss of quality. In summarizing its findings, WHCRI cited the long-term potential for increased quality: "Had QAP carried out more timely monitoring of nursing home performance from a statewide perspective and provided needed feedback, upgrading of quality of care might have occured more as proposed." The evaluators also noted that the latitude afforded surveyors in deciding whether an expanded survey or IoC review was needed tended to work against consistency in the screening process, and possibly cut down on the potential for time reallocation.

Massachusetts

The Massachusetts Department of Public Health conducted a formal demonstration of its Survey by Exception (SBE) process from July 1980 to September 1982. Massachusetts' modified process was based on the premise that the intensity of regulatory effort in each facility should be geared to the needs of that facility. The major objective of SBE was to reduce surveyor time spent on routine activities in the higher quality facilities in order to permit reallocation of surveyor time to the poorer quality facities. It was anticipated that such a system would maintain a constant quality of care in acceptable and outstanding facilities while producing improved quality in facilities with poor past performance records.

Process

Under the SBE system, nursing homes were classified into three groups based upon their performance histories. These classifications determined which type of survey was to be performed. Facilities rated outstanding received a screening survey consisting of an examination of ten broad areas of patient care conducted by a single surveyor through a one day "walk through" inspection. Facilities with acceptable records of past performance were surveyed with an abbreviated instrument consisting of 54 regulatory items from the traditional survey. These 54 items were selected by Massachusetts as the most important regulatory requirements and were by nature more focused and specific than the areas examined under the screening survey. In all cases where a screening or abbreviated survey was used, the surveyor could make an on-site decision to increase the intensity of the survey up to a full survey. All facilities classified as poor performers received the full traditional survey, consisting in Massachusetts of 627 items. One additional change instituted under the SBE process was a reduction from two person survey teams to a single registered nurse. No changes were implemented in the State's IoC review system, which remained completely separate from the survey process.

Evaluation

Mathematica Policy Research, Inc. (MPR) conducted the formal evaluation of the Massachusetts demonstration project. The evaluation design included the use of control nursing homes in Massachusetts, permitting a direct comparison of the impact of the new and old survey methods during the same time period. The major findings of the evaluation were as follows:

1) Screening and abbreviated surveys took less time to complete than traditional surveys, resulting in an overall decrease of 10.6 percent in average surveyor time per facility under the SBE process. (Note that time allocation comparisons for both Massachusetts and New York are based on time estimates constructed from the survey records, which MPR determined were more reliable than the States' time reporting systems.)

2) There was an increase in time spent in low quality homes (14.5 percent) and a substantial decrease in high quality homes (-31.9 percent), indicating that Massachusetts' new method did produce a reallocation of surveyor resources toward low quality facilities.

3) Surveyors under the new method detected significantly less total deficiencies, although this decrease was not reflected in the number of formal citations, but only in recommendation-type (uncited) deficiencies. The total number of deficiencies remained constant in low quality homes.

4) MPR detected a "highly significant" increase in the average severity of deficiencies detected under the new survey method, due to the higher frequency of deficiencies in resident care and environment/infection control areas as opposed to administrative deficiencies.

Although Mathematica supported the overall screening/sampling approach implemented by Massachusetts, they cited a number of design weaknesses in the State's process. Some of these weaknesses, such as the non-existent use of guidelines and the lack of linkage between the screening survey and applicable State and Federal codes, were offset to a large degree by the very high of caliber of nurse surveyors in Massachusetts. With less experienced surveyors, MPR felt that the State's system may not have functioned nearly as well. Mathematica also recommended a much larger resident sample size for intensive review, stating that without an integrated IoC and survey process, the SBE screening instrument was inadequate in terms of resident-specific information due to its very limited sample size of 2-3 residents. As a result, surveyors were sometimes unwilling to approve a facility based solely on the screen and tended to follow it with an abbreviated survey in order to satisfy their own standards. In conjunction with increasing the in-depth review sample size, another recommendation was that Massachusetts augment its survey teams by adding a second team member (usually a non-RN) in all but the smallest homes. Finally, MPR recommended that the State integrate its IoC and survey review processes.

New York

In September 1980, New York's Department of Health was approved to conduct a demonstration involving modifications to both the survey and inspection of care processes until September 1983. The demonstration was subsequently approved for continuation until implementation of the new national survey process. As detailed in Chapter Nine, HCFA is now considering a proposal to further extend New York's innovative IoC process to explore how the State's IoC process, along with its experimental reimbursement design, will interface with the new survey process. Like in Wisconsin and Massachusetts, the primary goal of New York's demonstration was to reallocate surveyor resources to marginal or poor facilities and improve the quality of care in these facilities. This involved the development of a streamlined IoC and survey process that prioritized activities dealing most directly with the resident care process while de-emphasizing areas of perceived paper compliance. New York's demonstration project included a modified IoC process, integration of IoC findings into the survey process, and a new survey process based on screening concepts.

Process

The revised IoC process consisted of a two-stage review of eleven items known as Sentinel Health Events (SHEs) intended to focus directly on patient care. Based on regulatory items, the SHEs were essentially negative outcomes (such as cases of decubiti, indwelling catheters), the presence of which were evaluated for each resident in a facility through a structured protocol of resident observation and record review. During Stage I, reviewers determined the incidence of SHEs among all residents and then compared the level of incidence for each SHE to a Statewide norm.

If the incidence level exceeded the norm, a Stage II review was triggered, consisting of a structured review of each occurence of the SHE to determine whether the facility employed the proper preventative and therapeutic measures in its care process. As with the Stage I review, findings were compared with statewide norms, and if the proportion of problems exceeded the norm, the facility failed that particular protocol. If the facility failed Stage II either overall or for a particular SHE, these findings influenced the scope of the survey, which typically followed immediately after the IoC review.

New York's new survey methodology utilized four sources of information to determine compliance: State agency files on facility history, a Facility Survey Report (FSR) form completed by each provider, IoC results, and an abbreviated onsite inspection. The FSR covered organizational structure requirements based almost entirely on documentation. The onsite survey was a highly focused review encompassing 250 essential Federal and State requirements (compared to 1250 items under the traditional survey). Based on the findings of the abbreviated survey and the IoC review, the survey team used set criteria to decide whether to conduct a more intensive survey. An intensive survey could consist of either a full review of all the traditional survey items or a partial survey of the traditional items in just those conditions or standards that were out of compliance.

One final noteworthy change under New York's new system is that deficiencies were cited only if standard or condition level requirements were not met. As long as the associated standard was in compliance, element level deficiencies were not cited as formal code violations but noted as deficiencies in the survey team's informal recommendations. The impact of this change would be evident in the evaluation results.

Evaluation

Like in Massachusetts, MPR conducted the formal evaluation of New York's demonstration project. Since the State implemented its new system on a statewide basis in 1981, the evaluation design of necessity utilized a before-after comparison technique. The primary conclusions of the evaluation were as follows:

1. "Strong and consistent" evidence indicated a substantial reduction in surveyor time under New York's new methodology, and most of this reduction could be traced to survey, rather that IoC activities.

2. MPR found no evidence of any time reallocation from high to low quality homes. However, a New York State study did evidence such reallocation, and the issue has been further addressed during the extension of the demonstration.

3. Under the new methodology, there was a large and significant decrease in the average number of deficiencies cited and a slightly smaller but still significant increase in the number of deficiencies noted as recommendations. Further analysis showed that this net decrease in deficiencies was confined almost entirely to high quality homes though, and across all homes, surveyors using the new method were more likely to cite conditions and standards as out of compliance.

4. The average severity of deficiency increased under the new method, with a greater average severity for both recommendations and citations. This increase in average severity was more than offset by the decreases in total deficiencies detected, resulting in a decline in the total severity per facility.

In its overall assessment of New York's new system, MPR stated that it was very well designed but that there were some shortcomings in the implementation of the process, particularly in the area of survey/IoC linkage. They recommended complete integration of survey and IoC reviews, rather than just a required sharing of findings. MPR also suggested that NY develop a way of ensuring the correction of element level deficiencies that were being addressed only as informal recommendations by survey teams.

As in each of the other demonstrations, the findings in New York solidly supported the theory that a modified survey methodology could produce overall time savings, although time reallocation to lower quality facilities could not be consistently shown. MPR stated its belief that, "Given the overall reduction in time, the prospects for meaningful reallocation exists under the new methods." Such time reallocations should eventually result in quality improvements in the facilities that need it most. Further, the evaluation concluded that New York's modified survey process was an "effective and efficient vehicle" that was "helping reduce the paperwork load and encouraging closer examination of resident-centered issues."

California

In an effort to increase the efficiency of its survey and certification program, the California State survey agency submitted a proposal in 1981 to conduct an experimental survey methodology in the State's skilled nursing facilities (SNFs). The intent of California's Abbreviated Survey Process (ASP) was to reduce the time and costs involved in surveying SNFs while maintaining acceptable quality of care. California's basic premise was that continued annual surveys were critical but that the intensity of the survey should vary according to the performance of the facility. The California experiment was approved by HSQB from 10/81 until 9/84.

Process

California's ASP consisted of three major elements:

- An abbreviated survey form composed of 152 of the 534 Federal requirements, chosen for their direct relationship to resident health and safety;

- A facility self-questionnaire, to be filled out by the administrator and key staff, covering another 104 organizational-type items; and

- A protocol detailing facility eligibility for the ASP as well as critieria for when surveyors must revert to surveys of greater intensity.

The ASP was designed to serve both as a time-saving device and a screening mechanism to alert the survey team to serious problems. If no problems were found using the abbreviated form, it was assumed that deficiencies in unsurveyed requirements would have little impact on resident welfare. Any finding that a standard was not met caused the applicable Condition of Participation to be surveyed in its entirety. If a surveyor determined non-compliance with a condition, the full traditional survey was instituted. The ASP was not designed for application to all SNFs but only to those facilities with good compliance histories.

Evaluation

Approval for the California experiment was granted contingent on the development of an evaluation methodology by HCFA's Division of Health Standards and Quality (DHSQ), Region IX. The Regional Office developed the California Abbreviated Survey Evaluation System (CASES), a 12-month review that was implemented from October 1981 to October 1982. The CASES methodology was based mainly on the analysis of Federal monitoring surveys of 75 percent of all California SNFs, as well as some before-after ASP analysis of deficiency and time utilization data.

The major findings of CASES were as follows:

1) The ASP was used in 45 percent of all California SNFs with an average of 36 percent time savings in surveying those facilities.

2) Abbreviated surveys produced a 16 percent savings in survey expenses.

3) Surveyors exhibited an apparent tendency to be "more lenient" in identifying nursing and pharmaceutical deficiencies in facilities receiving the ASP.

4) Statistical analysis indicated that eight survey items, primarily in the areas of infection control and drug administration, needed to be added to the ASP because of potential for impact on quality of patient care. (These items were added to the ASP during the experiment's extension period.)

Developed foremost as a cost-saving measure, California's ASP was limited in the respect that it addressed no fundamental reforms but simply experimented with a reduced number of items from the traditional survey form. In that the ASP requirements were closely aligned with an early set of HCFA "key requirements", the experiment did serve to pinpoint areas that needed to be, and have been, more fully addressed in the modified national survey instrument. In addition, the California experiment reinforced the overall belief that a cost-effective survey process could be designed which could achieve continued quality assurance by focusing on those items most directly related to patient care.

Washington

In October 1981, Washington's Bureau of Nursing Home Affairs submitted a proposal to conduct a modified survey process (MSP), which was designed to reduce overall surveying time, reallocate limited resources to poor facilities and to focus on the actual provision of care rather than on a facility's structural capacity for adequate care. Washington's experiment was approved to continue until the initiation of the new national survey process.

Process

The primary feature of the MSP was the abbreviated survey form which is utilized in all long-term care facilities. This form retained all regulatory requirements directly related to resident health and safety while eliminating those identified as "paper compliance," i.e., items focusing on internal management practices and documentation. Washington assumed that compliance with the targeted requirements would assure that a facility met the standards concerning the structural framework of care delivery. The State developed guidelines that, together with the shortened form, attempted to define the specific intent of each regulation in relation to the care needs of the residents. (As originally conceived, the MSP also included a system of extended survey cycles based on specific criteria related to a facility's survey results and compliance history. However, this system remained in effect for only 1 year after which Washington resumed annual surveys.) A final facet of the MSP was a performance-based criteria set for determining whether facilities needed onsite follow-up surveys, in contrast to the previous system of 100 percent onsite follow-ups.

Evaluation

The Hesperides Group conducted the formal evaluation of Washington's MSP, submitting its final report in March 1985. Earlier in the experiment, DHSQ Region X had conducted its own evaluation of the MSP, but Washington had objected to some of the findings based on perceived weaknesses in the study design.

Consequently, both the State and the regional office were involved in developing the design of the Hesperides evaluation, which examined the comparability of the MSP with the traditional Federal survey process in the areas of deficiency findings and resource utilization. The evaluation consisted of dual surveys of 21 randomly selected State nursing homes by four two-person surveyor teams. Each home received both a traditional survey and the MSP within a 1-week period. The results of the evaluation are summarized below:

1) The MSP was more likely to recertify a facility than was the traditional process. However, this finding was clouded by the fact that one of the traditional survey teams was especially prone to citing conditions out of compliance, thus denying recertification.

2) Although the MSP cited more severe deficiencies, the traditional process cited a greater number of deficiencies. Deficiency findings were notably similar in such key areas as nursing and medical care and patient safety.

3) The MSP moved less readily from marking out elements and standards to marking out conditions, even when supporting deficiencies were severe. In general, the total number of deficiencies, rather than their severity, was a stronger influence on the surveyor's decision to mark out both standards and conditions and on the overall certification decision.

4) The MSP did not vary significantly from the traditional process in terms of surveyor resource utilization. This finding was in variance with the State's own prior data indicating a 4-5 hour time saving per survey using the MSP. Interestingly, prior data also showed that State surveyors during the study found twice as many deficiencies as had been noted in the most recent past State survey, possibly indicating greater thoroughness on the part of study surveyors.

In summary, the results of the Hesperides Group evaluation were generally in agreement with the previous Region X evaluation of the Washington experiment, which indicated, based on limited evidence, that the MSP produced fewer deficiency citations and more lenient certification decisions than the traditional process. Neither evaluation was particularly conclusive, and as Hesperides stated, "...these results present a picture of two acceptable processes which are fairly comparable in their outcomes although different in their interests." The evaluation results did provide some insight into which areas of care delivery were better reviewed by the traditional survey, and thus needed to be carefully addressed in the national modified process.

Iowa

From January 1983 until the implementation of the new national survey process, the Iowa Department of Health was approved to conduct its Outcome-Oriented Survey (OOS) process in intermediate care facilities, composing 90 percent of the State's nursing homes. The intent was to shift the emphasis of the survey process as much as possible from policies and procedures to measurable outcomes of services provided.

Process

The OOS was a screening device that led to indepth review where necessary. A condensed version of Iowa's traditional form, the OOS form contained only those requirements considered critical indications of the quality of health care provided to nursing home residents (about 150 of the 700 traditional items). Under the OOS system, a single surveyor normally applied the screening instrument in each facility. One notable element of the screening survey was the random selection of a 10 resident sample for intensive review, including private interviews and a review of medical records and care plans. Throughout the OOS form, a significant effort was made to utilize a concrete, quantitative measurement system, replacing "yes or no" answers with scale measures wherever possible. This system was intended to lead surveyors through the decision-making process and eventually to produce a numerical data base for facility evaluation and problem identification.

After review of the OOS results, Iowa used thresholds for determining if a more intensive survey was needed. Administrative staff determined whether further review was necessary, and if so, either a partial or full survey was performed by a nurse other than the one who completed the OOS. Iowa estimated that partial and/or full surveys, based on its traditional licensure survey, were triggered in about 10 percent of facilities since January 1983.

Evaluation

Rehabilitation Care Consultants, Inc. (RCC) conducted the formal evaluation of Iowa's OOS process. Major elements of the evaluation design included:

1. A detailed comparison of a sample of Federal and OOS surveys to determine the degree of agreement on the number and severity of deficiencies found; and

2. Validation activities such as the performance by RCC of both Federal and OOS surveys, as well as the application of an independent quality assessment tool in a much smaller sample of nursing homes.

The primary conclusion of RCC's analysis was that Iowa's experimental process identified fewer problems, and problems of less severity, than did the traditional Federal survey. These findings held true even when analysis was restricted to those areas covered by both survey instruments.

RCC identified a number of problems in both the design and the application of the OOS process that had implications for the national implementation of a modified survey process. For example, RCC recommended that the practice of selecting a set number of residents at random for intensive review be changed to at least a partially targeted sample with sample size proportional to resident population. In terms of application, RCC noted that some Iowa surveyors failed to use the summary section of the OOS form, and had a generally negative attitude toward the new process based on their perception that the new tool severely restricted professional judgment in reporting problems. Problems of this nature highlighted the need for surveyor training and clear guidelines in order to minimize surveyor misperceptions and achieve uniformity in the national implementation process. Finally, RCC concluded, as did Mathematica in its evaluation of the Massachusetts demonstration, that at least two surveyors were needed on each inspection team.

Rhode Island

Rhode Island was the final State approved by HCFA to develop and conduct an experimental survey approach. Originally approved as an experiment from October 1983 until September 1986, Rhode Island's planned methodology stressed the elimination of "paper review" and the intensified review of resident care, emphasizing the assessment of resident outcomes. The State intended to capitalize on its integrated IoC/survey review system by using the resident care assessments in the IoC process for all resident care components of the survey process.

As Rhode Island began to develop a draft survey instrument and an experimental application design, several factors came to light that eventually resulted in the combination of the Rhode Island process with the PaCS survey process. First, it was apparent that there were significant similarities between the State's approach and the newly developed PaCS process. In addition, demonstration results from the two other States with integrated IoC/survey review systems, Wisconsin and New York, were beginning to indicate the efficacy of many of the same concepts proposed for further testing in Rhode Island. Finally, HCFA realized that its own modified survey process was close to being ready for extensive testing and that a "laboratory" for rigorous testing would be needed.

In May 1984, HCFA staff proposed to the Rhode Island Department of Health that the State merge its developing methodology with the PaCS process and serve as an evaluation site for the proposed national process. Such a merger offered the following major advantages:

- Rhode Island had already been working in conjunction with Brown University's Long-Term Care Gerontology Center on developing an experimental design for a comprehensive project evaluation that was readily adaptable for HCFA's purposes.
- The State's prior commitment to the concept of outcome-oriented surveys ensured a high degree of acceptance of the new survey process among surveyor staff.

Rhode Island agreed to HCFA's proposal and, during the summer of 1984, staff from the State's Division of Facilities Regulation worked with HCFA staff to incorporate selected procedural elements and resident evaluation indicators from the State's proposed survey form into the PaCS form and process. The merger was completed prior to the initiation of national testing of the PaCS process in December 1984.

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CHAPTER THREE

PaCS: THE EARLY STAGES

Introduction

The new national long-term care survey process being implemented in 1986 is the product of an extended developmental effort. HCFA's continuing objective has been to provide a better link between facility surveys and care review through a revision of the traditional survey forms and process.

In 1982, HCFA staff evaluated numerous survey and IoC approaches and instruments in an effort to identify and categorize specific performance indicators directed at the care actually provided by the facilities. They also reviewed the various models governing the use of these indicators. The review encompassed a wide range of programs including the formal State demonstrations and experiments, other States' integrated IoC/survey procedures, former Professional Standards Review Organizations review systems, industry quality assurance tools, and unrealized past Federal approaches such as the Patient Care Management System and the Patient Appraisal and Care Evaluation instruments. Drawing on each of these sources, HCFA staff completed development of the original version of the PaCS survey instrument in September 1983. Although the subsequent testing and refinement process have resulted in numerous revisions to the PaCS form and procedures, the new long-term care survey process maintains the essential features of PaCS. The new approach continues to emphasize review of the provision of resident care and services through an integrated system of resident observation, interviews and record reviews.

The First PaCS Trial

The original PaCS instrument was used for the first time on October 15-18, 1983. Central office surveyors conducted a pretest of the tool in three Maryland nursing homes to see if it was a viable review mechanism. The surveyors recommended several changes in the length and formatting of the survey form but agreed that further testing was merited. After instituting the recommended revisions, HCFA unveiled the PaCS instrument to the groups involved in the Subpart S meetings in November 1983, and with their support, prepared for its first formal field testing.

Pilot Test 1

Following 2 days of surveyor training in December 1983, PaCS was field tested in three regions between 12/16/83 and 1/20/84. The test involved the performance of parallel PaCS and traditional surveys in four facilities in each region, encompassing a cross-section of compliance histories. For comparability purposes, both sets of surveys were limited to 2 days and restricted to the same resident record sample. The study was intended to provide an indication of the effectiveness of PaCS in terms of quality, cost, and administration, as well as to identify areas of the tool in need of refinement.

Findings of the pilot test supported the continued refinement of the new survey process. PaCS and traditional surveyors tended to identify the same general problem areas (e.g., restorative care, nursing services) but differed in the specific provisions cited. PaCS surveyors more frequently noted direct care problems (e.g., aseptic techniques, ambulation), while traditional surveyors more often identified organizational or structural problems (e.g., nursing policies, maintenance of equipment). A comparison of findings did reveal a weakness in the PaCS process in the area of infection control and sanitation. Problems in those areas usually turned up through the inspection of equipment, storage areas, kitchens, etc., which was not originally included in the PaCS review.

Early indications were that the PaCS survey could be completed in an hour's less time than the traditional survey, despite the greater amount of time spent on the facility tour and resident focused review under PaCS. Surveyors and facility staff expressed a generally favorable reaction to the new system, particularly its emphasis on care review as opposed to paper compliance. Residents liked the idea of being more involved in the survey process although it was suggested that the length of the resident interviews needed to be reduced. Other recommendations produced by the first PaCS pilot testing included:

- Refine the PaCS forms to make them more concise and easier to follow through by individual resident.
- Provide more space for surveyor notes and commentary.
- Supplement the PaCS survey with a conventional review of infection control and sanitation.
- Emphasize interviewing and observational skills in the PaCS survey or training program.

Despite the small size of the sample, HCFA was encouraged by the result of the pilot test and continued its efforts on a number of fronts to achieve eventual national implementation of a modified long-term care survey process. Program staff began working with the Office of Management and Budget (OMB) to obtain forms clearance to implement large-scale national testing of the PaCS process. At the same time, they continued refining the format and content of the survey instrument based on results of the initial testing as well as subsequent comments from the American Health Care Association (AHCA), the National Council of Health Centers (NCHC), and the American Association of Homes for the Aging (AAHA). The State of Rhode Island, which had been in the process of developing its own resident-centered survey methodology, also took part in the refinement effort, agreeing to participate in an intensive evaluation of the national model instrument rather than continuing to develop its own tool. A second small scale pilot test of the PaCS process was scheduled in order to gain some experience with the refined instrument. HCFA than contracted with Rehabilitation Care Consultants, Inc., (RCC) to obtain an independent, professional assessment of the tool through a review of its components, observation of the pilot surveys and utilization of the tool by RCC staff.

Pilot Test 2

The PaCS model was field tested for a second time in Kentucky, Illinois and Pennsylvania from July 16 to August 8, 1984. Once again, Federal surveyors performed parallel PaCS traditional surveys under controlled conditions to ensure comparability. The nine participating facilities were volunteers from the AAHA, AHCA and NCHC.

Results of the second pilot test were similar to the earlier findings in that the new survey process detected more resident care problems but was judged in need of further format changes to enhance ease of use. The one PaCS surveyor who had also taken part in the previous pilot test consistently identified a greater number of overall deficiencies than the traditional surveyor (particularly in such resident-related areas as activities, social services, physician services, nutrition), indicating the possibility of a 2-3 survey learning curve for effective use of the new process. Although the second pilot test did not detect any time savings under the PaCS methodology, there was a clear redistribution of survey time to resident-oriented activities such as observation, interview and record review. (Note that the infection control and sanitation areas were more fully covered in this version of the tool, probably accounting for the lack of any time savings.) Surveyors made the following specific recommendations for improving the process:

o Reduce the length of the resident observation/interview form, if possible using a checklist format.

o Develop a better vehicle for summarizing findings.

o Provide procedural guidelines applicable to each portion of the survey form.

Overall reaction from surveyors, facilities and residents continued to be favorable.

RCC's independent assessment of the new survey method was based on a detailed review of each of the components of the PaCS form and guidelines, observation of the instrument in use by a Federal surveyor, and RCC's own utilization of the PaCS forms. Citing the soundness of the PaCS concept, RCC stressed the need for a thorough and consistent training program to educate State surveyors in both the philosophy and implementation procedures of an outcome-oriented process. Other major recommendations stemming from RCC's descriptive analysis included:

o Decrease the cumbersome nature of the working instrument by separating all background and guideline type information.

o Add a one-page facility tour worksheet to the working instrument.

o Develop separate and expanded procedural guidelines applicable to each portion of the form, emphasizing the guidelines for the general facility tour.

- Expand the eating assistance observation section to include crossmatching of diet cards and physician's order with actual meals served for a sample of residents.

- Include interviews with facility staff in the survey process.

- Emphasize importance of surveyor judgment in selection of a targeted resident sample for indepth review.

RCC also made several recommendations related to the PaCS care guidelines, such as additional or amended care indicators addressing catheters, colostomies, decubiti and others. All of the above major recommendations and many of the more specific suggestions were eventually incorporated into the new long-term care survey process.

Preparation for National Testing

Following the two encouraging pilot tests, HCFA staff began to prepare in earnest for large-scale national testing of the PaCS process, pending departmental clearance of the survey forms. After making further refinements to PaCS based on surveyor and RCC recommendations from the second pilot test, they submitted the modified forms to OMB and requested approval to have States conduct PaCS surveys in nursing homes with particularly good compliance histories. Approval was requested to have the majority of States perform PaCS surveys in from 3-20 facilities, depending on the total number of facilities in the State, and to have surveyors complete a questionnaire regarding their impressions of the PaCS forms and process. HCFA also requested permission to conduct a formal test of the PaCS process in Rhode Island, Tennessee and Connecticut, involving an extended group of facilities in each of these States.

During the latter part of 1984, as the PaCS forms made their way through the departmental clearance process, HCFA began to train surveyors in using the PaCS process. Surveyors from Rhode Island, Tennessee and Connecticut received training in October. During November and December 1984, HCFA staff conducted a series of training workshops to instruct surveyor representatives from all regional offices and States in using PaCS. Despite some opposition from surveyors who felt that the PaCS form was too long and cumbersome, there was strong overall support for the concept of resident-oriented surveys focusing on care delivery and outcomes rather than process. The training staff also encountered significant surveyor misunderstanding as to the intent of the PaCS process, especially the perception that PaCS was a shortened survey process that omitted regulatory requirements and resulted in less paperwork for the surveyor. When it was emphasized that the form was being implemented on a trial basis and that further revisions to both the form and the process would be made based on test results and surveyor suggestions, they expressed a general willingness to cooperate.

The Executive Office of Management and Budget granted approval for States to begin using the PaCS forms and questionnaires in January 1985. Brown University has conducted the formal evaluation of the PaCS process in the three demonstration States of Rhode Island, Tennessee and Connecticut, where surveyors conducted PaCS surveys throughout 1985. Both RCC and the HCFA regional offices have conducted evaluations of the limited national testing, which took place in the other 47 States between February 1 and June 30, 1985. Ensuing sections of this report discuss the objectives, design and results of this two-track evaluation effort.

CHAPTER FOUR

THREE-STATE FORMAL TESTING OF THE NEW SURVEY PROCESS

Introduction

Brown University's Long Term Care Gerontology Center has conducted the formal evaluation of the new long-term care survey methodology. The Brown evaluation was based on the result of extensive testing of the PaCS process during late 1984 and 1985 in the States of Rhode Island, Tennessee and Connecticut. It focused on the reliability and validity of the new survey process and also examined such important sub-issues as resource utilization and surveyor and facility acceptance. Presented below is a report on the design and objectives of the study, as well as a discussion of Brown's preliminary findings based on the partial data now available. Complete results of the evaluation will be available by June 1986.

Demonstration States

Rhode Island, Tennessee and Connecticut comprised the formal laboratory for testing the new survey process prior to its national implementation. The selection of these demonstration States was based both on their willingness to participate in the evaluation and on the diversity that the States had to offer in terms of facility type, team size and composition, and review approach. Their continuing cooperation in the timely performance of scheduled surveys as well as the allotment of valuable staff time to participate in the PaCS implementation workgroup was invaluable to the refinement of the new survey methodology.

Rhode Island was the first State selected for formal testing of the modified survey process. As noted earlier, Rhode Island had developed its own outcome-oriented survey process in consultation with Brown University. Late in 1983, Rhode Island applied to HCFA to conduct a State experiment. In view of the progress that had been made towards implementation of a new national survey protocol, HCFA decided not to initiate another experiment, but to attempt to enlist the State's cooperation in refining and testing the PaCS process. Rhode Island was agreeable to this suggestion, and its staff collaborated with Federal staff to incorporate elements of the Rhode Island process into PaCS. In addition to improving the Federal survey design, the collaboration with Rhode Island also offered the advantage of Brown University's evaluation methodology, which had been specifically developed for the State's outcome-oriented process. This evaluation protocol was expanded to encompass the other two demonstration States.

The second State selected for participation in the formal PaCS testing was Tennessee. Like Rhode Island, Tennessee had submitted in May 1984 a proposal for an integrated survey and inspection of care review experiment. HCFA again responded that the time table for implementing a revised national survey model did not permit further experimentation by individual States, and instead, obtained the State's consent to take part in testing the national model. Although both Rhode Island and Tennessee had integrated survey and IoC reviews, Tennessee employed a less intensive IoC procedure based on the 100 percent review of selected key indicators (as opposed to Rhode Island's 100 percent in-depth review). Tennessee also offered an opportunity to test the national model with very large survey teams (at least eight members) in an environment of predominantly intermediate care facilities, in contrast to Rhode Island's 4-5 member teams surveying a mixture of SNFs and ICFs.

Connecticut was the final State that agreed to participate in the PaCS demonstration. In contrast to Rhode Island and Tennessee, Connecticut maintained a non-integrated system of surveys and IoC reviews. Nearly all of the State's nursing homes were dually certified (as SNFs and ICFs) and survey team size and composition depended on individual home characteristics such as size and deficiency history. Connecticut's basic PaCS survey team was composed of two nurses, as opposed to the larger, multi-disciplined teams prevalent in Rhode Island and Tennessee.

Evaluation Issues

Brown's evaluation of the new survey methodology included four major areas of investigation: deficiency detection, impact on resident outcomes, consistency of problem identification and deficiency citation, and a comparison of surveyor costs. The evaluators also collected and analyzed information on the perceptions of nursing home administrators and staff and all involved surveyors regarding the PaCS process through detailed questionnaires to each group. Other issues explored by the evaluation include: the effectiveness of the PaCS sampling process and selection criteria, effectiveness of triggers, assessment of process problems using PaCS, ability of surveyors to accurately calculate ADL (Activities of Daily Living) scores, the appropriate future use of ADL score changes, and the relative effectiveness of PaCS in SNFs versus ICFs and "poor" facilities versus "good" facilities.

Evaluation Design

Each of the three involved States had a distinct experimental design. These designs were tailored by Brown to meet the variability of processes in each State while at the same time addressing the long list of research issues in which HCFA was interested.

The most sophisticated research design was implemented in Rhode Island, where nursing homes were randomly assigned into an experimental group and a control group. Double surveys were administered in the 60 experimental homes, with the traditional team preceding the PaCS team in homes surveyed prior to April 1 and the order reversed in homes surveyed after that date. Only the PaCS survey team provided the experimental group homes with exit interviews and official deficiency findings. In the control group, consisting of approximately 45 homes, only the traditional survey was administered. This design permited a comparison of PaCS versus traditional findings in the experimental homes as well as a comparison of traditional survey results in the control versus experimental homes, thus assessing the possible impact of experimental conditions on the traditional survey outcomes. Since the Rhode Island sample contained a good mix of SNF and ICF homes, Brown was able to compare the ability of the PaCS process to evaluate quality in two different settings within one State. Rhode Island's 100 percent intensive IoC review also provided the longitudinal resident level data (such as ADL scores) needed for a study of the impact of the new survey process on resident outcomes. Finally, Rhode Island surveyors initiated the use of onsite portable computers to collect resident-specific data from the in-depth sample, an innovation with significant future implications.

The evaluation design in Connecticut also called for surveyors to conduct both traditional and PaCS surveys, this time in 45 nursing homes with the exit interview and deficiency findings given by the traditional team. The 45-home sample was then stratified into three 15-home groups reflecting the perceived quality of the homes based on an analysis of deficiency data from previous years. Through this stratification, Brown could provide some insight into the effectiveness of the PaCS process in nursing homes of different quality.

In Tennessee, the new survey process was administered in all three regions in the State, encompassing about 90 nursing homes. Since a double survey design comparing traditional and PaCS results was not feasible, analysis of the new survey's impact on deficiency findings had to be based on comparison with prior year deficiency data. In one region in Tennessee, however, surveyors conducted follow-up PaCS surveys in 30 homes immediately following the initial PaCS survey. This design was intended to permit assessment of inter-rater reliability in terms of problem and deficiency determination using the new methodology. Brown also analyzed PaCS deficiency findings from both Tennessee and Connecticut to examine the efficacy of the 10 percent resident sample for intensive review and the related selection criteria.

Evaluation Results

Although the final evaluation report is not scheduled for submission until June 1986, Brown provided HCFA with a series of interim reports presenting its preliminary findings. These "results" should be approached with the understanding that they are based on partial data and cannot be statistically verified until final data is available. Some of the proposed research issues, such as the impact of PaCS on resident outcomes, could not be addressed with the available data. The questions that were analyzed using the preliminary data include:

- What is the impact of PaCS on the number, types, and severity of deficiencies?
    - How effective is the triggering approach?
    - To what extent is PaCS appropriate for both SNFs and ICFs, and to what extent does it work in different quality homes?
- To what extent are surveyors consistently deciding when a problem is a deficiency?
- To what extent does PaCS compare with the traditional survey in terms of resource use?
- To what extent is the PaCS methodology consistent across survey teams?
- How accurate are PaCS surveyors in monitoring ADL scores?

- What are the impressions of nursing home administrators and nursing directors regarding the PaCS process?
- What are the impressions of surveyors regarding the PaCS process?

A discussion of the preliminary findings in each of these areas follows.

Impact of PaCS on Deficiencies

The primary measure of nursing home quality of care provided by the survey process is the deficiency. In addition to tabulating total deficiencies from each survey, Brown developed three-tier classification systems to examine the type and severity of each deficiency.

As displayed in Table 1, Brown found that PaCS survey teams cited considerably more deficiencies in Tennessee, somewhat more deficiencies in Rhode Island, and considerably fewer deficiencies in Connecticut than did teams using the traditional survey. A breakdown of the total deficiencies into discrete categories revealed that the substantially lower deficiency total in Connecticut could be attributed mainly to a large reduction in the average number of documentation deficiencies. Moreover, the PaCS team in Connecticut still found more patient care deficiencies, and a much higher proportion of patient care deficiencies, than did surveyors in the other two demonstration States. In all three States, the PaCS teams found a higher proportion of patient care deficiencies. Another significant finding was that the PaCS survey was equally or more effective than the traditional process in detecting environmental deficiencies, with evidence of more environmental deficiencies in Rhode Island and Tennessee, and a higher proportion of such deficiencies in Connecticut. (This finding is notable in that the physical environment review portion of the new survey process had been strengthened on the recommendation of surveyors who took part in the PaCS pilot testing.)

TABLE 1
Deficiencies by Type, Survey Type, and State

	Connecticut		Rhode Island		Tennessee	
	PaCS	Traditional	PaCS	Traditional	PaCS	Traditional
Patient Care	2.93 (45.85)*	4.00 (21.89)	1.57 (25.24)	0.88 (17.81)	2.43 (21.02)	1.16 (15.83)
Documentation	2.33 (36.46)	12.47 (68.25)	3.65 (58.68)	3.78 (76.52)	7.11 (61.51)	4.44 (60.57)
Environment	1.13 (17.68)	1.80 (9.85)	1.00 (16.08)	0.28 (5.67)	2.02 (17.47)	1.73 (23.60)
Total	6.67	19.40	7.71	6.19	13.46	8.05

*Percentages are of the summation of Patient Care, Documentation, and Environment, not Total.

(Note: Patient Care, Documentation, and Environment categories include only tags that are unique in substance to avoid double counting. No conditions are included, but some standards are included. Many standards duplicate substance of elements. Total deficiencies include all tags cited. Therefore, total deficiencies is larger than the sum of the categories by the number of conditions and the number of "non-unique" standards.)

In terms of severity, Brown found that few condition level deficiencies were cited using either survey method. In both Rhode Island and Tennessee, the PaCS teams cited more standards and critical deficiencies than did the traditional teams while the reverse was true in Connecticut (see Table 2). Condition level deficiencies are generally the most severe while standard level deficiencies are serious but not enough to warrant facility closure. Critical deficiencies combine standards with elements to represent problems that are judged important to ensuring the health and safety of residents. Brown indicated that the most clearcut finding in this area was that the PaCS process was citing significantly more severe deficiencies in Tennessee.

TABLE 2
Severity of Deficiencies by Survey Type and State

	Connecticut*		Rhode Island*		Tennessee*	
Severity Measures	PaCS	Traditional	PaCS	Traditional	PaCS	Traditional
Conditions	--	0.07	--	0.05	0.04	0.44
Standards	0.20	0.93	2.05	0.86	4.38	2.62
Criticals	0.13	0.40	0.71	0.24	2.00	0.76

* Average per home.

Triggering

As implemented in the 1985 testing, the PaCS process included a triggering mechanism to prompt the review of certain policy and procedure items when a deficiency is cited in a related patient care area. In the traditional process, these items were always reviewed directly. As would be expected, Brown found that the triggering process resulted in fewer deficiency citations for these items, providing for the reduction in documentation-type deficiencies found with PaCS. The triggering mechanism was deleted from the new national survey methodology based on the lack of any conclusive supportive evidence from Brown or from RCC's process-oriented evaluation, as well as overwhelmingly negative feedback on triggering's utility from PaCS surveyors. The new methodology still permits surveyors to verify compliance with requirements not included in the PaCS process, at their discretion.

PaCS in Different Quality Facilities

Brown's evaluation of the PaCS survey results in nursing homes of different quality, which was drawn solely from Connecticut facilities, indicated slightly fewer deficiencies using PaCS in the "good" quality group and considerably fewer deficiencies in the "average" and "poor" groups. These differences were attributed almost totally to differences in the number of documentation deficiencies. Brown noted that the reduced reporting of documentation problems under the PaCS system has apparently changed the State's perceptions of the quality of many of its nursing homes.

PaCS in SNFs and ICFs

The final element of Brown's analysis of deficiency findings concerned the ability of the PaCS process to evaluate care in SNFs as opposed to ICFs. Based on a sample of 20 Rhode Island homes, Brown found that the new process had much more impact in the intermediate care setting. In ICFs, the PaCS team found 6.75 deficiencies per home, compared with 2.38 per home found under the traditional process. In SNFs, there was a less pronounced difference, with the PaCS team identifying 6.50 deficiencies per home, while the traditional team found 5.67 per home. The final evaluation report will present further analysis in this area.

Consistency of Deficiency Citations

Under the new survey methodology, surveyors complete an observation/interview record review form (OIRR) for each resident who is included in the intensive review sample. The OIRR form is a checklist for recording negative findings directly associated with patient care. As Brown's preliminary report pointed out, the PaCS recording process provides substantial insight into criteria used in the decision-making process for determining deficiencies, thus making feasible an analysis of the consistency of support for deficiency citations. This is in contrast to the traditional survey where there was no formal problem identification and surveyors rely on informal notes to document deficiencies.

Brown performed a detailed analysis of the OIRR form from each PaCS survey to ascertain whether a relationship existed between the number of "negative findings" and the number of patient care deficiencies cited. Table 3 summarizes Brown's preliminary findings, presenting a State-by-State breakdown of the median total negative findings and the number of negative findings per observed resident for homes with differing numbers of patient care deficiency citations. Listed below each State is the number of facilities on which the data is based.

TABLE 3
Patient Care Deficiencies versus Negative Findings

	Patient Care Deficiencies	Median # of Total Negative Findings	Median Negative Findings per Resident
Connecticut (N=15)	0 - 1	85.0	7.1
	2 - 3	72.0	7.1
	4 - 5	82.0	7.5
Tennessee (N=46)	0	58.0	3.8
	1	61.5	5.1
	2 - 3	61.0	4.2
	4 - 5	73.0	6.9
	6+	130.0	8.4
Rhode Island (N=18)	0	325.0	11.4
	1	759.0	11.1
	2 - 3	761.0	11.4
	4+	797.5	11.7

Keeping in mind that surveyors in Rhode Island conducted intensive review on a much larger but somewhat less disabled sample, there was still a large cross-state variation in the number of negative findings per resident. The average number of negative findings per resident ranged from 6.0 in Tennessee to 7.6 in Connecticut to 11.5 in Rhode Island. Brown noted that only in Tennessee did a demonstrably positive relationship exist between the number of negative findings per resident and the number of patient care deficiencies, (ranging from 3.8 in homes without deficiencies to 8.4 in homes with six or more deficiencies), although in all three States the highest number of average negative findings correlated with the homes with the greatest number of patient care deficiencies. Brown also indicated that there was generally a positive relationship between the total number of negative findings and the number of deficiencies, with the most pronounced relationship again being found in Tennessee (ranging from 58 such findings in homes without deficiencies upward to 82 problems in homes with six or more deficiencies sited). The results from Tennessee were particularly encouraging because the majority of all homes included in this sample came from that State (46 of 79 homes, 58 percent). HCFA will continue to evaluate the consistency of the relationship between negative findings and cited deficiencies as surveyors gain more experience with the new survey methodology, since there was some evidence of inconsistent use of the OIRR form during the testing period. Unlike its predecessor, the new survey process has the potential to produce numerical norms and standards for determining when patient care problems warrant deficiency citations, once it has been in use long enough to establish base-line data.

Resource Utilization

Brown's resource use analysis was based on time distribution information submitted by individual team members in the experimental States. Since there were differences among the survey/IoC review approaches of the three States (see the Evaluation Design section), Brown's analysis concentrated on intra-State comparisons. The evaluation structure permitted a direct comparison of traditional and PaCS survey time only in Connecticut and Rhode Island; no traditional surveys were done in Tennessee. Brown found that the PaCS team in Connecticut spent considerably less person-hours per home than the traditional team members (an average of 20.9 person hours per PaCS survey versus 33.3 person hours per traditional survey), but more time in all areas of resident review--e.g., increased nurse review time per resident, increased overall average time spent in sample resident record review, interview and observation. Specifically, PaCS surveyors spent 65.9 percent of their total time in intensive resident review compared to 26.6 percent for the traditional surveyors, including a reported 21.0 percent interviewing time under PaCS versus 6.8 percent during the traditional survey.

In Rhode Island, Brown reported that the PaCS teams spent more person-hours per home than the traditional team (55.0 hours versus 46.8 hours), with very similar distributions of time for both of surveys. For example, the proportion of total interviewing and direct observation time was 29.1 per cent with PaCS and 27.8 with the traditional survey. Average surveyor record review time was somewhat higher using PaCS, indicating that surveyors may have been experiencing problems coordinating the PaCS record review process with their IoC review responsibilities. The greater average time spent in patient interviewing and observation in Rhode Island could be attributed to the inclusion of the IoC sample with the survey.

Although a time comparison of PaCS and the traditional survey was not possible in Tennessee, Brown reported that the amount and distribution of record review, interview and observation was similar to that of Connecticut. Tennessee's nine-member teams spent an average of 58.6 person hours per facility, with 19.7 percent of that time reportedly spent in interviewing residents.

Overall, the preliminary resource utilization findings reflected the new methodology's potential for redirecting and eventually saving surveyor time while maintaining or increasing the efficacy of the survey. The time distribution results in Connecticut were particularly notable since, as a State without an integrated survey/IoC process, Connecticut most typified the review structure in the majority of the non-experimental States. Although data on total survey time may be influenced by the varying team sizes across States and survey types, increases in the proportion of direct resident review time would be a significant step forward. The procedural guidelines for the new survey methodology contain recommendations to reduce the variability in survey team size in order to increase the uniformity and efficiency of the new survey process. HCFA also anticipates that once surveyors have more experience with the PaCS methodology and forms, there may be consistent time savings associated with the new process.

Inter-rater Reliability

The double PaCS survey format in Tennessee was designed to test the consistency of PaCS findings across survey teams. Since the double survey results were available from only three of thirty scheduled facilities, Brown's preliminary report contained no conclusive findings on inter-rater reliability using PaCS. Early results unexpectedly showed that in each case, the second survey team to enter the home found more deficiencies that did the first, prompting some concern about experimental design features (e.g., which team should give the exit interview?). Brown's final report will not only examine the consistency in the number and type of deficiencies but also explore whether the variability is in the detection of problems or in the determination of what problems are severe enough to warrant a deficiency.

ADL Scores

Nursing homes in Rhode Island have begun to perform functional assessment on residents using the Katz ADL scale, a measure developed by Dr. Sidney Katz to ququantify a resident's ability to perform basic activities such as bathing, dressing, toileting, etc. This information, which is of great potential use for case mix reimbursement systems, has been verified and collected on a sample basis in the State by nurse interviewers from Brown with extensive training and experience in this area. As part of the Rhode Island experiment, surveyors were instructed to calculate an ADL score on the PaCS form for each sample resident based on medical record information concerning functional levels at admission. Brown then matched these scores with the verified ADL assessments collected by the trained interviewers to determine the accuracy of the scores calculated by the surveyors. This comparison revealed only a 35.7 percent level of matching scores and a considerable number of large discrepancies between the surveyor scores and the nurse interviewer scores.

Surveyors were also instructed to assess the accuracy of the latest ADL score in the record after completing their observation and interview of each sample resident. Brown's final report will include a comparison of these current (as opposed to admission-based) ADL scores. However, the preliminary data clearly indicated that surveyors requird more extensive training on determining ADL scores than the two sessions provided the Rhode Island surveyors in order to accurately determine ADL scores. For the present time, the new national survey process does not require surveyors to score residents in ADLs. HCFA will reevaluate the feasibility of requiring surveyors to do ADL scoring after surveyors have been trained in and gain experience with the more fundamental elements of the new survey methodology.

Impressions of Nursing Home Administrators

Brown's preliminary report presented the results of 52 approximately one-hour interviews with nursing home administrators who had experienced the PaCS survey process. The Directors of Nursing Services (DNS) were also present at most of the interviews. Although these interviews provided admittedly subjective information, a surprising majority of the administrator/DNS group shared opinions on many aspects of the process.

The administrator/DNS group reported diverse levels of knowledge about the PaCS process both before and during the demonstration project, but previous knowledge levels or attitudes had no measurable affect on their opinions about the new methodology. Overall, they supported the concept of a more resident-oriented, less paper-oriented survey process. They reported similar relative burdens for both survey processes in such areas as surveyor time in the facility, disruption to staff and residents and preparation time. The majority of respondents (57.7 percent) agreed that new survey process focused on more valuable information than the traditional survey while only two administrators (3.8 percent) felt that it focused on less valuable information. Two-thirds of the administrator/DNS group, reported that the PaCS process provided a better assessment of the quality of nursing home care. Thus after experiencing a PaCS survey, the group supported not only the concept of a resident-oriented survey but also the ability of the new survey process to successfully embody this concept, with over 80 percent stating that they would prefer a PaCS survey to the traditional process.

Impressions of Surveyors

Brown conducted interviews with a sample of 34 surveyors who had participated in the PaCS demonstration to determine their impressions of the new methodology. The interviews focused on their perceptions of the efficiency and effectiveness of each form involved in the PaCS process, along with some general questions concerning the overall process. As with the administrator/DNS group, the majority of surveyors appeared to concur on many aspects of the process.

One area of the PaCS process that generated nearly unanimous support was the drug pass form. Nearly 90 percent of the surveyors felt that this was a positive addition to the survey methodology with the remaining respondents unsure. The accompanying pharmacy record review summary also received solid support with about 50 percent of surveyors citing it as a positive addition while only one surveyor saw this review as a negative addition. On the other hand, demonstration State surveyors were consistently opposed to other elements of the experimental process, particularly the PaCS tally sheet and triggering mechanism. Fully 75 percent of the respondents favored elimination of the tally sheet, over 50 percent opted to eliminate triggering and 87 percent reported either that they never used the triggers or that the triggers were not helpful in providing guidance for additional review. These findings, in conjunction with similar feedback from other surveyors experienced with PaCS, contributed heavily to HCFA's decision not to include the tally sheet and the formal triggering mechanism in the new long-term care survey process.

A large majority of surveyors (75 percent) supported the elimination of required review of policies and procedures, with nearly two-thirds of the surveyors interviewed agreeing that such review was usually unnecessary to determine the quality of patient care. Notwithstanding general concurrence that a resident-oriented survey could best help to ensure quality care, the surveyors made clear that a more standardized information collection process could succeed only if it were "workable" in the facility. This attitude was exemplified by surveyor reaction to the OIRR form. Surveyors recognized the value of the information collected by the in-depth review process, despite the additional time demands involved, but they were not satisfied with the design and length of the OIRR form. Thus while no surveyor indicated that the OIRR should be implemented as is, nearly two-thirds suggested that the form should be revised and implemented, compared to only about 20 percent who favored elimination of the form. HCFA staff worked extensively with the PaCS surveyor workgroup to refine both the OIRR form and the summary form to ensure that the new forms facilitated a resident-oriented approach without resulting in an excessive paperwork burden for surveyors.

Some resistance to changes in the nursing home inspection process was to be expected among experienced surveyors, especially in view of the extremely flexible approach to assessment engendered by the traditional survey process. Surveyor concerns were intensified by the widespread belief among surveyors (84 percent) that they did not receive adequate training prior to the implementation of the experimental process. Still, almost 40 percent of the interview group felt that the new process collected more valuable information than did the traditional survey, with a similar proportion responding that the two processes yielded information of equal value. HCFA believes that the combination of refinements in the survey process together with a well-developed, standardized surveyor training program will produce increasing levels of surveyor acceptance.

REFERENCE

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CHAPTER FIVE

NATIONAL TESTING OF THE NEW SURVEY PROCESS

Introduction

The second facet of HCFA's two-track evaluation effort involved the limited national implementation of the PaCS process in the 47 non-demonstration States. Between February 1 and June 30, 1985, State surveyors conducted over 350 surveys in nursing homes with good compliance histories. Rehabilitation Care Consultants analyzed the survey results and surveyor questionnaires from this part of the PaCS testing. Each HCFA regional office also monitored the implementation of the new process through the performance of a limited number of PaCS and traditional surveys in each State. This nationwide testing served both to foster surveyor and facility familiarity with the new resident-oriented process as well as to provide HCFA with broad-based feedback on the specific strengths and problems of PaCS. Presented below is a discussion of the evaluation design, results and recommendations from the RCC and regional office studies.

RCC Study: Evaluation Design

RCC's evaluation of the PaCS process was by design a primarily descriptive analysis since, unlike in the three demonstration States, the national group of nursing homes surveyed did not represent a scientifically selected sample. RCC focused on how well surveyors were implementing the formative PaCS process and made recommendations regarding elements of the PaCS survey forms and procedures that needed clarification or modification. Following completion of its evaluation of the PaCS process, RCC was further charged with developing draft procedural guidelines and training materials for the conduct of PaCS surveys, based upon the conclusions reached from its review.

RCC's analysis was based on the following specific sources of information:

- o Observational Surveys--RCC observed a total of nine State survey teams conducting the PaCS process in the States of Colorado, Massachusetts, Missouri, Illinois and Wisconsin. This review focused on the relative effectiveness of specific elements of the process (e.g., the forms and guidelines, the mechanisms for detecting and documenting findings and then linking them to deficiency citations, the appropriateness of the sampling methodology, etc.).

- o Surveyor Questionnaires--RCC reviewed and summarized the results of approximately 100 PaCS surveyor questionnaires representing 44 States in order to ascertain the level of surveyor acceptance and to identify problematic areas of the PaCS survey methodology.

- o Survey Report Forms--RCC reviewed all completed PaCS survey report forms, focusing on basically the same sort of issues as did the observational surveys. This portion of the study also required RCC to select stratified samples of up to 30 facilities each in order to assess the PaCS process with respect to variations in team size, team composition, facility size and facility type.

In addition, RCC kept abreast of Brown's findings in the three formal evaluation States and reviewed the evaluation reports from all previous survey demonstrations and experiments in formulating its findings.

RCC Study: Results

Results of RCC's nine observational surveys combined with its analysis of surveyor questionnaires to yield similar suggestions as to the main areas that needed to be addressed prior to full national implementation of the new survey process. These areas included:

- Simplifying the forms to make them easier to use;
- Developing more specific procedural guidelines instructing surveyors in how to apply the new inspection methodology; and
- Most importantly, greatly emphasizing the quality and amount of surveyor training in the new process.

As detailed later in this report, HCFA has responded to each of these issues through the use of a surveyor workgroup to refine the PaCS forms and streamline the format, the development of strengthened procedural guidelines and the introduction of a structured surveyor training program, respectively.

On the whole, surveyors indicated that they liked the PaCS concept but were not comfortable with the forms. Approximately half of the surveyors questioned reported that the PaCS process was more effective than the traditional survey (51 percent), identified problems that may have gone undetected (54 percent), and enabled them to spend more time observing care provision and talking to residents (46 percent). (The remaining surveyors either responded negatively or felt that PaCS had no impact either way.) However, fully 71 percent of the respondents indicated that they had difficulty understanding or appying portions of the PaCS survey, particularly the tally sheet, IORR form, ADL checklist, and the summary form. Reports of problems in these areas were corroborated not only by RCC's findings from its observational surveys, but also by Brown's findings in the three-State formal evaluation. Finally, a large majority of the surveyors (76 percent) believed that they had not received adequate training prior to PaCS implementation.

RCC's review of the completed PaCS survey reports also offered insights into several specific process-related issues, as well as assessing the possible impact of variations in team size and composition and facility size and type on the utility of the PaCS process. It concluded that the PaCS forms, if used correctly, fostered a logical decision-making process with appropriate documentation to support deficiency citations. This was in contrast to the traditional survey which was considered not to allow a logic trend to be followed in any retrospective type of review. However, RCC found that surveyors were not generally using the process correctly, particularly the tally sheet and the triggering mechanism. Noting that the triggering mechanism was not producing anticipated results, RCC indicated that the process warranted further study prior to national implementation. It again stressed the need for more extensive surveyor training and pinpointed the correct usage of forms, the formulation of deficiency statements and the selection of a representative cross-section of residents for in-depth reviews as areas on which surveyor training needed to focus.

The limited examination of the impact of size and composition and facility size and type on the PaCS process produced few firm findings. For example, RCC identified few differences in how surveyors applied the new process or the results they obtained in facilities of varying total resident populations or certification status. As represented in Table 1 below, RCC did find that many more deficiencies were cited in SNFs and in dually certified facilities than in ICFs.

Table 1
Deficiencies by Certification Status

Sample Sizes
ICF 16
SNF 30
ICF/SNF 29

	ICF	SNF	ICF/SNF
Number of Total Deficiencies for All Surveys in Sample	80	365	278
Average Number of Deficiencies Per Survey	5.0	12.2	9.6
Number of Deficiencies Oriented to Structure/Paper	55	235	169
Average Number Per Survey	3.4	7.8	5.8
Number of Deficiencies Resident Centered/Quality of Life	24	100	78
Average Number Per Survey	1.5	3.3	2.7
Number of Deficiencies Directly Threatening	1	36	31
Average Number Per Survey	0.06	1.2	1.1

However, the same trend towards the identification of a greater number of deficiencies holds true for the entire nursing home universe, based on the results of the most recent annual survey for all homes as of January 1986:

	ICF	SNF	ICF/SNF
Average Number of Deficiencies Per Survey	7.8	14.8	14.5

(Note that the RCC data encompassed less than 100 facilities selected based on their good compliance histories while the national data was derived from surveys on almost 9,000 SNFs and 7,000 ICFs of all quality types.)

In terms of survey team composition, RCC's findings were also generally inconclusive, although it did recommend the use of multi-disciplinary teams including at least one RN. The area of team composition was thought to warrant further study. Another issue recommended for further study was that of the effect of various team sizes on the survey process. However, as exhibited in Tables 2 and 3 below, RCC's data indicated that teams comprising two to four surveyors tended to cite more and better-documented deficiencies than did smaller or larger teams.

Table 2
Deficiencies by Team Size

Sample Sizes	
1 Surveyor	30
2 Surveyors	29
3-4 Surveyors	27
5 or More Surveyors	30

	1 Surveyor	2 Surveyors	3-4 Surveyors	5-more Surveyors
Number of Total Deficiencies for All Surveys in Sample	183	282	334	237
Average Number of Deficiencies Per Survey	6.1	9.7	12.0	7.9
Number of Deficiencies Oriented to Structure/Paper	132	147	221	128
Average Number Per Survey	4.4	5.1	7.9	4.3
Number of Deficiencies Resident Centered/Quality of Life	15	75	104	112
Average Number Per Survey	0.5	2.6	3.7	3.7
Number of Deficiencies Directly Threatening	34	57	9	4
Average Number Per Survey	1.1	2.0	0.3	0.1

Table 3
Defiency Documentation by Team Size

Sample Sizes	
1 Surveyor	30
2 Surveyors	30
3-4 Surveyors	29
5 or More Surveyors	30

	1 Surveyor	2 Surveyors	3-4 Surveyors	5-more Surveyors
Notes Adequate to Support Deficiencies Cited:				
Yes:	12/28* 43%	21/30 70%	19/29 66%	13/30 43%
No:	16/28* 57%	9/30 30%	7/29 34%	17/30 57%

* Two surveyors had no deficiencies cited.

Based on this data and other information culled from review of the State modified survey projects, the procedural guidelines for the new survey process recommend two to four surveyors as the optimum team size.

RCC Study: Further Recommendations

RCC's overall findings were highly supportive of the core PaCS process, including the execution of an in-depth facility tour, the use of targeted sampling, the intensive review of that sample including observation, interview and record review, increased emphasis on dining and eating assistance issues, the drug pass observation, and the logical incorporation of survey findings into deficiency citations via the PaCS summary form. HCFA has addressed many of RCC's recommendations (e.g., forms simplication, increased emphasis on training) in preparation for implementing the new survey process. However, both RCC and HCFA share the belief that the new survey process is still a formative one, and one that needs to continue to evolve if it is to fully achieve its objectives. As RCC stated, "Concepts central to PaCS...are the way of the future and HCFA should continue its ongoing efforts to refine and reshape the process." It offered the following recommendations for future modifications to the survey and certification process and areas in need of further study:

o Utilize the concept of screening surveys that can trigger a more intensive survey if results warrant.

o Conduct further studies on the issues of team size and composition.

o Improve the interface of the survey system with enforcement procedures.

o Refrain from implementing any form of pre-survey questionnaire since such a vehicle would eliminate any unpredictability from the timing of the survey process.

- Continue to seek and utilize surveyor input into the survey modification process.
- Consider developing regulations related to care outcomes.
- Pursue the integration of IoC and survey review throughout the country.

A number of these issues are discussed in Chapter Nine of this report, which deals with HCFA's short- and long-term objectives involving the new survey process.

HCFA Regional Study: Evaluation Design

A much more limited evaluation of the national testing of the PaCS process was carried out by the Division of Health Standards and Quality of HCFA's ten regional offices. From March to July 1985, each region was to conduct at least four monitoring surveys per State to evaluate the implementation of the PaCS process and the utilization of the PaCS forms. The bulk of these surveys were strictly observational, with the Federal surveyors accompanying their State counterparts. In addition, regional staff also conducted a smaller number of comparative Federal monitoring surveys, using both the traditional and the PaCS processes to resurvey the same facilities subjected to PaCS surveys by the States within a 4-week period. This allowed surveyors to simultaneously gain experience with the new survey process and to informally evaluate consistency between the State PaCS survey findings and the findings of PaCS and traditional monitoring surveys.

HCFA Regional Study: Results

The regional findings provided further evidence that surveyors were uncomfortable with the PaCS forms and generally found them cumbersome to use. This was particularly true of the OIRR form and the tally sheet. Surveyor concern over the adequacy of the training program was also reiterated. They specifically cited the need for expanded procedural guidelines in order to clarify perceived problem areas such as the triggering procedures and the decision as to what constitutes a deficiency. On the positive side, regional surveyors were enthusiastic about the drug pass and the fact that the PaCS process focused on resident care and outcomes. They agreed that the resident-centered approach allowed the surveyor to comprehensively follow a specific resident and to observe the total care pattern, thereby promoting the identification of systemic resident care problems.

Table 4 and 5 below present summarized comparisons of State and Federal findings from 44 surveys. Table 4 contains the results of State and Federal PaCS surveys in 22 facilities. Table 5 compares the findings from State PaCS surveys with traditional Federal surveys in another group of 22 facilities.

Table 4
Deficiency Totals: PaCS vs. PaCS

	States PaCS Survey	Federal PaCS Survey
Patient Rights	18	16
Physicians Services	10	24
Nursing Services	79	76
Dietetic Services	39	41
Pharmacy	9	10
Patient Activities	13	17
Infection Control	33	18
Social Services	4	3
Rehab. Services	0	4
Total Patient Care Deficiencies	205	209
Physical Environment	49	36
Other	24	22
Total Deficiencies	278	267
% of Patient Care Deficiencies	73.7%	78.2%

Table 5
Deficiency Totals: PaCS vs. Traditional

	States PaCS Survey	Federal Traditional Survey		
	PaCS Tags	PaCS Tags	Structural Tags	RO Total
Patient Rights	19	7	56	63
Physicians Services	23	28	22	50
Nursing Services	84	58	88	146
Dietetic Services	29	10	54	64
Pharmacy	5	3	34	37
Patient Activities	9	14	8	22
Infection Control	16	0	29	29
Social Services	7	13	0	13
Rehab. Services	5	2	1	3
Total Patient Care Deficiencies:	197	135	292	427
Physical Environment	35			39
Other	28			108
Total Deficiencies:	260			574
% of Patient Care Deficiencies	75.8%			74.4%

Analysis of Table 4 reveals that the total number of patient care deficiencies was very similar in State and Federal PaCS surveys. Both sets of surveyors identified more than 50 percent of all deficiencies in the areas of nursing services and dietetic services. Table 5's comparison of the State PaCS surveys with the traditional Federal surveys indicated that the regional surveyors were citing considerably more overall deficiencies. However, more than two-thirds of the deficiencies cited under the traditional method can be classified as structural items, with the State surveyors actually identifying a greater number of direct care deficiencies than the Federal surveyors and a comparable number of physical environment deficiencies. These results were not based on a scientifically selected sample, and no severity analysis is available for this survey comparison. Further analysis did reveal that in no case did the States and regions disagree in terms of citing a regulatory condition of participation as out of compliance.

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CHAPTER SIX

THE NEW LONG-TERM CARE SURVEY PROCESS

Introduction

Beginning in the Spring of 1986, HCFA will mandate the use of a new methodology for surveying nursing homes that is intended to focus the inspection process more directly on the actual care provided to residents. The new onsite process and survey reporting forms are designed to incorporate preferred components of the modified survey approaches tested in various States since 1978, as well as adopting portions of other approaches that stress the delivery and outcomes of resident care. As this report has detailed, the new survey process has been subjected to an extensive testing, evaluation and refinement effort since its introduction in December 1983. This section of the report explains how the new survey process will work and highlights several of its most innovative features.

Overview: Smith v. Heckler Case

The primary purpose of the new long-term care survey process is to better assess whether high quality care is actually being furnished to Federal beneficiaries in the nation's nursing homes. Although the onsite inspection methodology has been modified considerably, nursing homes are still required to be in continuous compliance with all current regulations in order to be certified. The regulations setting forth the quality assurance requirements for SNFs (42 CFR Part 405, Subpart K) and ICFs (42 CFR Part 442, Subpart F) have not been changed. The only regulatory changes involved in implementing the new process are minor modifications to two sections of the regulatory code dealing with certification procedures (42 CFR 405.1906 and 42 CFR 442.30). The effect of the changes is to explicitly require State survey agencies to use the survey methods, procedures and forms prescribed by HCFA in its current general instructions.

The impetus for introducing the new survey process via a regulatory change was a court order from the United States District Court in Colorado stemming from The Estate of Smith v. Heckler case. This order was the result of a suit filed in 1975 on behalf of residents in a Colorado nursing home in which plaintiffs claimed that HHS had failed to carry out its duty to ensure that Medicaid patients in nursing homes were actually receiving high quality care. After extended judicial proceedings, HHS eventually responded that it had developed a revised survey system that would enable HHS to better determine the actual quality of care provided. The court then ordered the Department to develop and publish a Notice of Proposed Rulemaking (NPRM) regarding the new survey process. In response to the court order, HHS published an NPRM (Federal Register, Vol. 50, No. 211, October 31, 1985, pg. 45584) describing its intent to implement a new outcome-oriented survey process in 1986 and setting forth regulatory language mandating State use of HCFA's survey forms and procedures. As in the past, the forms and procedures themselves were not set forth in regulations. However, copies of the new forms, methodology and guidelines were made available to all interested parties during the NPRM process. In November 1985, plaintiffs in the Smith v. Heckler case requested that the court enjoin the rulemaking process, instruct HHS to publish another NPRM containing all new survey forms, methods and procedures, and extend the period for public comment on this information until at least 60 days after the publication of the Institute of Medicine's study on the survey process. On December 27, the court announced its decision not to interfere with the rulemaking process and denied the plaintiff's motion to enjoin.

This effectively cleared the way for HCFA to implement the new survey process as planned in the Spring of 1986, following publication of the final rule. Under the new methodology, a complete long-term care facility survey essentially will consist of three components--a review of administrative and procedural requirements (Part A), a review of requirements directly impacting resident care (Part B), and the traditional review of Life Safety Code requirements. Parts A and B are embodied in the new two-part survey forms, HCFA-525 and HCFA-519, which replace the HCFA-1569 and HCFA-3070 forms in both SNFs and ICFs.

Part A of the New Survey Process

Part A of the new survey process consists of a review of the organizational and procedural requirements specified under all current Conditions of Participation. The Part A form includes requirements for both SNFs and ICFs in the following areas:

- written administrative and resident care policies
- bylaws and other organizational documentation
- written agreements with outside resources/consultants
- committee meeting and reporting requirements
- staff qualifications and written development programs
- other written programs, plans or systems (e.g. equipment maintenance, disaster preparedness)

Unlike the traditional survey forms, Part A does not provide a verbatim presentation of each regulatory condition, standard and element. Instead, it sometimes restates the essential nature of each administrative and procedural requirement and references the appropriate regulatory citation for SNFS and/or ICFs as applicable.

Use of Part A

Surveyors will conduct an onsite evaluation of the Part A requirements only for initial surveys. Facilities not meeting these requirements will not be certified for participation. Part A will not be applied for resurveys of participating LTC facilities. At the time of resurvey, a facility would be required to attest in writing that there have been no administrative or procedural changes that would affect Part A compliance and that it agrees to notify the State agency immediately of any changes in its organization or management which may raise questions regarding continuing compliance. The State agency will then determine, through a Part B survey, whether such changes have had an adverse effect on the qualify of resident care. If the quality of care has been adversely affected, the State agency may verify compliance with the requirements contained in Part A.

Part B of the New Survey Process

Part B of the new survey is the refined version of the resident-oriented process that has been known heretofore as PaCS. All SNFs and ICFs will receive a Part B survey on an annual basis. The Part B process and forms concentrate on the areas of the traditional survey that are directly related to resident care (nursing services, physician services, dietary services, resident activities, etc.). The new approach stresses resident outcomes and the actual provision of care and services. Surveyors will cite deficiencies directly from the review of resident care and treatment rather than from a review of policies and procedures.

The Part B survey is designed to provide a more valid and reliable assessment of the quality of care furnished by a nursing home. By bringing surveyors face to face with a representative sample of residents, it enables surveyors to more accurately identify resident needs and problems and, subsequently, to determine how well care is being provided to meet those needs. In addition, by requiring surveyors to follow specific procedures and to perform resident review using a specified checklist, Part B promotes greater consistency in methodology and findings than has been achieved under the traditional process. Consider the following examples:

- In the traditional process, surveyors could evaluate a facility's policies and procedures to ascertain that grooming and personal hygiene rules were designed to satisfy resident needs. Under the new process, surveyors must determine whether these needs are actually satisfied. This requires the surveyor to observe residents and to note that they are in fact clean and well groomed. Information provided by the residents can also be used to determine whether such needs are regularly met.

- In the traditional process, surveyors could review a sample of medical records to determine if restorative nursing procedures were performed daily and recorded. The new process requires surveyors to speak with residents about the frequency of the care and treatments received, in addition to observing and documenting the frequency of care for comparison with the medical record.

- In the traditional process, surveyors could review a facility's policies and procedures to ensure that there was a written disaster preparedness plan. Under the new process, surveyors are instructed to question facility staff regarding their awareness of such a plan and their individual responsibilities towards the residents.

As can be seen in the examples above, the new survey process embodies many of the preferred techniques now used by surveyors in conducting the traditional process. Under the new process, however, all surveyors will be expected to employ such techniques. In addition, a major innovation of the Part B survey is the requirement that surveyors complete worksheets evaluating a sample of residents in the areas of general care, nutrition and medication administration. An evaluation of these areas, along with an in-depth tour of the facility that also includes a structured worksheet, form the four major activities of the new survey process.

Entrance Conference

As always, before proceeding with the care review aspects of the survey, surveyors hold an entrance conference to introduce themselves to facility staff and explain the basic steps of the survey process. Other activities that surveyors take care of at the entrance conference include:

- Requesting that the facility complete the Resident Census portion of the HCFA-519 as soon as possible so that the information can be used in the subsequent survey process;
- Asking the facility to post a notice that the surveyors are in the facility and available to meet with residents; and
- Making arrangements to meet with representatives of the facility's resident council, if applicable.

Resident-Centered In-depth Tour

Following the entrance conference, the first major component of a Part B survey is an in-depth facility tour designed to assess the general state of the facility and its residents and to identify potential problems. Part B procedural guidelines stress that the tour should focus on the resident's needs and whether or not those needs are being met. The tour should accomplish three specific purposes:

- First, the tour is used to scan each resident in terms of individual needs. This will require the surveyor to spend approximately 3 hours in the tour activity for every 100 residents. The scanning process evaluates care for numerous items including grooming and hygiene, positioning, interaction with staff, restraints, and respect for residents' rights. The surveyor notes resident-specific problems as well as patterns of care that demand further investigation.
- Second, the tour is used to identify residents for in-depth reviews. Generally, residents selected for in-depth review should be representative of the facility population, exhibit a variety of care needs, and include those exhibiting potentially poor outcomes. The sample should consist of heavy care and light care residents. Both of these groups should include residents who are alert, confused and those unable to communicate. Procedural guidelines instruct surveyors to utilize the resident census data provided by the facility to assist in choosing a representative resident sample.
- Finally, the tour is used to evaluate the physical environment of the facility. Each resident's room is evaluated in addition to common resident areas. Issues of health and safety, infection control and personal expression are evaluated. Additionally, other structural concerns such as staff awareness of disaster procedures are covered.

In addition to scanning individual residents, the tour should also focus on assessing the residents as a group in order to detect overall patterns and trends of care. Pertinent findings about care patterns and resident condition, along with resident identification information, should be noted by the surveyor on the Tour Notes Worksheet (Exhibit 1). This information assists the surveyor in selecting a resident sample and in focusing attention on possible problem areas.

Observation/Interview/Record Review of Sample Residents

After selecting residents for in-depth review, surveyors evaluate the physical condition of each sample resident according to a prescribed observable criteria set (see Exhibit 2, OIRR Worksheet). The purpose of the in-depth review of a sample of residents is to determine if the facility is consistently meeting the needs of residents. While making these observations, surveyors conduct brief interviews with the resident and/or staff in order to gain additional information about the resident's condition and facility care patterns. Interviews should last approximately 15 minutes depending on the needs and wishes of the resident. Surveyors also note the behavior and level of awareness of confused residents and those unable to communicate in order to reconcile resident needs with the plan of care in the record. Documentation of resident interview data is in accordance with the surveyor's need to specifically recall information for survey findings. Staff interviews should focus on methods and frequency of care provision and other pertinent issues related to the care of each sampled resident. The surveyor should note whether applicable care processes or interventions (e.g., decubitus care) are being appropriately provided. Suggested interview questions as well as definitions of appropriate care and interventions are provided in guidelines.

Following the observation/interview, surveyors review the medical record of each sample resident. Surveyors may choose to perform an expanded record review to verify suspected problem patterns of care. Each record should demonstrate that the facility has adequately assessed all the resident's problems and needs, developed a plan of care, provided care accordingly, and evaluated the effectiveness of care.

After each in-depth resident review, the surveyor should summarize the findings on the OIRR worksheet, highlighting problematic areas. The summary process ensures that all essential information is readily available to be transferred to the survey report form and cues the surveyor to be alert for similar types of problems in other residents. Once all OIRR worksheets are completed, the surveyor reviews the summarized findings for evidence of poor care patterns and transfers the appropriate information to the survey report form.

Drug Pass Observation

The new survey process incorporates a major advance in the technique used by surveyors to evaluate a facility's medication administration practices. Rather than depending on a review of nursing notes or medication administration records to detect drug administration errors, the new "drug pass" methodology requires surveyors to observe the actual provision of drugs to residents. As part of the drug pass observation, surveyors note the drugs as they are poured for each resident, observe the actual administration of each drug and then check drug orders to determine whether the pour and the administration are done as prescribed. This methodology ensures that survey

HEALTH CARE FINANCING ADMINISTRATION

TOUR NOTES WORKSHEET

PROVIDER NUMBER

SURVEY DATE

INSTRUCTIONS

1 Note care and problems in care on all units
2 Report deficiencies directly to survey report form or evaluate further during indepth sample review
3 Select residents for indepth review
4 Select a proportionate number from each section

	INDEPTH SAMPLE		
Facility Bed Size	*< 80*	*80-200*	*200 +*
Sample Size	*5*	*10%*	*30*

OBSERVE RESIDENTS FOR THE FOLLOWING CARE PROBLEMS

GROOMING/PERSONAL HYGIENE

POSITIONING

ASSISTIVE DEVICES

AMBULATION

RESTRAINTS

HYDRATION

INFECTION CONTROL

PATIENT RIGHTS

OTHER

FORM HCFA-521 (11-86)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

OMB NO. 0938

OBSERVATION/INTERVIEW RECORD REVIEW WORKSHEET

PROVIDER NUMBER	VENDOR NUMBER	SURVEY DATE	OBSERVATION/INTERVIEW OF: (RESIDENT'S FULL NAME)

INSTRUCTIONS

1. *Observe each resident in sample to identify ADL needs and potential problems. Interview only residents in sample who are capable and willing.*
2. *Review each resident's record to ensure assessments, plans, interventions and evaluations are appropriate and current.*
3. *Note deficiencies on summary form after reviewing all residents in sample.*

NURSING NEEDS

ADL'S
- ☐ Bathing
- ☐ Dressing
- ☐ Toileting
- ☐ Transferring
- ☐ Continence
- ☐ Feeding

SKIN
- ☐ Tears/Wounds
- ☐ Ulcers
- ☐ Rashes
- ☐ Flaking
- ☐ Scaling
- ☐ Red Area

DECUBITUS
- ☐ Grade
- ☐ Foul Odor
- ☐ Draining
- ☐ Dressing
- ☐ Unclean
- ☐ Not Dry
- ☐ Not Intact
- ☐ Poor Technique

DRESSINGS
- ☐ Unclean
- ☐ Not Dry
- ☐ Not Intact
- ☐ Foul Odor
- ☐ Poor Technique

GROOMING/HYGIENE
- ☐ Eyes/Ears/Mouth
- ☐ Oral/Dental Hygiene
- ☐ Foot Care
- ☐ Facial Hair
- ☐ Hair/Scalp
- ☐ Nails
- ☐ Clothing
- ☐ Shoes/Slippers
- ☐ Odors

POSITIONING
- ☐ Contracted Extremities
- ☐ Improper Position
- ☐ No Protective Device
- ☐ Room Improper
- ☐ Lack of Turning as Needed
- ☐ Schedule Not Present
- ☐ Improper Techniques
- ☐ Aseptic/Other

RESTRAINTS
- ☐ Type
- ☐ Inappropriate Application
- ☐ Improper Body Alignment/Support
- ☐ Not Released/Exercised Every 2 Hours
- ☐ Chemically Restrained

INJECTIONS
- ☐ Site Red/Swollen
- ☐ Improper Technique
- ☐ Resident Reacts

PARENTERAL FLUID/IV'S
- ☐ Rate Incorrect/Stopped
- ☐ Site Red/Swollen
- ☐ Dressing Unclean
- ☐ Unsafe Splint
- ☐ Improper Label
- ☐ Outdated Solution
- ☐ No I/O Recording

BOWEL/BLADDER
- ☐ Not Routinely Toileted
- ☐ Commode Not Available
- ☐ Schedule Not Available

CATHETER
- ☐ Inappropriate
- ☐ Poor Drainage
- ☐ Drainage System Open
- ☐ No Urine in Bag
- ☐ Urine Leaking
- ☐ Abdomen Distended
- ☐ Tubing Not Clean
- ☐ No Intake/Output Record
- ☐ Supply Storage Unclean

COLOSTOMY/ILEOSTOMY
- ☐ Not Well Regulated
- ☐ Odors
- ☐ Diarrhea/Constipation
- ☐ Site Red/Irritated

RESPIRATORY
- ☐ Congested/Short Breath
- ☐ IPPB Not Available
- ☐ Oxygen Not Available
- ☐ Improper Equipment Use

TRACHEOSTOMY
- ☐ Site Red/Swollen
- ☐ Obstructed
- ☐ Unclean
- ☐ Improper Suctioning
- ☐ Equipment Not Available

SUCTIONING
- ☐ Audible Rales
- ☐ Labored Breathing
- ☐ Drainage
- ☐ Equipment Not Available

DIETARY NEEDS
- ☐ Over/Underweight
- ☐ Dehydrated
- ☐ Endema
- ☐ Emaciated
- ☐ Dull/Dry Hair
- ☐ Swollen/Red Tongue
- ☐ Bleeding Gums
- ☐ Cracked Lips
- ☐ Inability to Chew
- ☐ Swallowing Problem
- ☐ Pallor

TUBE FEEDING
- ☐ Nutrition Inadequate
- ☐ Poorly Tolerated
- ☐ Vomits
- ☐ Dehydrated
- ☐ Over/Underweight
- ☐ Diarrhea/Constipation
- ☐ Poor Skin Condition
- ☐ Poor Mouth Condition
- ☐ Improper Technique

OTHER
- ☐
- ☐
- ☐
- ☐
- ☐

REHABILITATION NEEDS
- ☐ Cannot Communicate
- ☐ Ineffective Use of Assistive Device
- ☐ Improper Equipment Use
- ☐ Improper Technique
- ☐ Equipment Inadequate

SOCIAL SERVICE NEEDS
- ☐ Not Oriented
- ☐ Not Able to Converse
- ☐ Uncooperative/Disrupts
- ☐ Withdrawn
- ☐ Anxious
- ☐ Confused
- ☐ Lonely
- ☐ Vision/Hearing Needs
- ☐ Mentally Retarded

PATIENT RIGHTS
- ☐ Privacy Not Maintained
- ☐ Staff Not Courteous
- ☐ Not Informed of Rights
- ☐ Mental/Physical Abuse
- ☐ Cannot Exercise Rights
- ☐ Cannot Manage Affairs

ACTIVITY NEEDS
- ☐ Not Participating
- ☐ Vision/Hearing
- ☐ Chair/Bedfast
- ☐ Dependancers ADL's

NOTES

FORM HCFA-524

SEE REVERSE

RECORD REVIEW

☐ Drug Regimen Reviewed

ROUTINE REPORTS: ☐ Weights ☐ Lab ☐ X-ray ☐ Other

ASSESSMENT	PLAN	INTERVENTION	EVALUATION

PHYSICIAN SERVICES

☐ Admission Information
☐ Rehabilitation Information
☐ Physical Exam
☐ Written Care Plan

☐ Signs Orders/Notes
☐ Required Visits
☐ Emergency Availability
☐ Review of Care

findings on medication administration are definitive and cannot be dismissed as documentation errors. Surveyors are instructed to conduct a drug pass observation on approximately 20 randomly selected residents per facility and to record individual findings on the Drug Pass Worksheet (see Exhibit 3). Any patterns or problems discerned from worksheet results are transferred to the survey report form under the appropriate rule.

Dining and Eating Assistance Observation

The fourth major component of the new survey process is the focused evaluation of meals, dining areas and eating assistance. Mealtimes offer surveyors a concentrated opportunity to observe how well a facility meets a primary need of a significant number of residents. Since not all residents eat in the dining room though, a surveyor should also devote attention to the provision of meals in other locations such as resident rooms. By observing how residents are being fed, how much help they need and receive, and how much food they eat, in conjunction with determining if meals agree with diet orders, a surveyor determines whether the facility is actually providing proper nourishment. The dining observation also provides information on a wide variety of nondietary issues such as staff interaction with residents, promptness and appropriateness of assistance, availability and use of adaptive equipment, appropriateness of dress and hygiene for meals, etc.

Surveyors use the Dining Assistance Worksheet (Exhibit 4) to record observations in this area, and two meals are generally observed. At each meal, surveyors are instructed to select a minimum of five residents for a comparison of meals served with the diet card and physician orders. A facility is also evaluated for how well it assesses, plans and provides for the nutritional and eating assistance needs of residents during the surveyor's indepth review of the ten percent resident sample. Findings from both the dining assistance worksheet and the in-depth resident review can contribute to appropriate areas of the survey report form.

Conclusion of a Part B Survey

Once the four major tasks of the Part B process have been completed, a survey team should identify patterns and areas where a facility appears to have difficulty in addressing problems and providing care. Surveyors must then formulate deficiency statements based on the severity and/or frequency of identified care problems. Although deficiency statements continue to depend to a large extent on subjective professional judgment, the new process ensures that each deficiency stems from resident-specific examples that are indicative of a breakdown in a facility's care delivery system. At the traditional exit conference concluding a Part B survey, a survey team should be able to provide specific examples of how a facility's deficiencies are impacting upon the quality of life for its residents.

Problem Correction and Follow-Up

Under the new survey process, surveyors are charged with the identification of care problems, rather than the responsibility for ascertaining the reasons for these problems (e.g., inadequate policies and procedures or inefficient organizational structure). A facility is expected to review its own care

DRUG PASS WORKSHEET

PROVIDER NUMBER	SURVEY DATE	ERROR RATE ☐

INSTRUCTIONS	DEFICIENCY FORMULA
1. Perform Drug Pass Observations on 20 Residents. 2. Record Observation of each Opportunity. 3. Compare Observation Notes with Physician Orders. 4. Calculate and Note Error Rate. 5. Note Deficiencies on Survey Report Form.	1. One or more Significant Errors = Deficiency 2. $\frac{\text{Significant + Non-significant}}{\text{Doses Given + Doses Ordered But Not Given}} \times 100 \quad \geq 5\% = \text{Deficiency}$

IDENTIFIER	POUR	PASS	RECORD
RESIDENT'S FULL NAME, ROOM NUMBER, TIME	DRUG PRESCRIPTION NAME, DOSE AND FORM	OBSERVATION OF ADMINISTRATION	DRUG ORDER WRITTEN AS: *(IF DIFFERS FROM ADMINIS ONLY)*

FORM HCFA-522 (11-86)

HEALTH CARE FINANCING ADMINISTRATION

OMB NO. [illegible]

DINING AREA & EATING ASSISTANCE WORKSHEET

PROVIDER NUMBER	SURVEY DATE

INSTRUCTIONS

TASKS 1. Observe Dining Area.
2. Note Meals Served/Review Physicians Orders
3. Note Assistance Provided
4. Note Deficiencies on Survey Summary Form

***SAMPLE A MINIMUM OF FIVE (5) RESIDENTS**

1. DINING AREA AND MEALS

- a. Size does not restrict movement.
- b. Accommodates all residents.
- c. Cleanliness.
- d. Adequate/comfortable lighting.
- e. Adequate/comfortable ventilation.

2. SERVING OF MEALS *

- a. Number of meals/time span between meal.
- b. Conformance to physicians order.
- c. Nutritional adequacy.
- d. Adequacy of portions.
- e. Residents eat approximately 75% of meals.
- f. Puree dishes served individually.
- g. Food cut, chopped or ground for individual resident needs.
- h. Acceptable taste.
- i. Proper temperature.
- j. Plates covered.

FORM HCFA-523 (11-85)

SEE REVERSE

2. SERVING OF MEALS * *(continued)*

k. Served promptly.

l. Residents ready for meal when served.

m. Attractive.

n. Utensils available.

o. Functional trays for bedfast residents.

p. Salt, pepper, sugar, other condiments on resident's trays unless contraindicated.

q. Medically able residents eating in dining area.

r. Bedtime nourishment offered.

3. SUPERVISION OF RESIDENT NUTRITION

a. Prompt assistance.

b. Proper assistance (spoon-feeding; supervision or instruction to develop eating skills).

c. Courteous and unhurried assistance.

d. Self-help devices present (straws, easy grip utensils, special cup, etc.).

e. Intake recorded/deviations from normal are reported.

delivery system to locate root causes for poor resident care. Following such review, a facility will be required to submit a plan of correction that identifies necessary changes to assure deficiency correction. A plan of correction should address the system level problems that may have resulted in a resident-specific problem or negative care outcome. Plans of correction specific to residents identified as examples of improper or inadequate care are not acceptable.

Follow-up surveys also differ from those conducted under the traditional process. Surveyors re-evaluate specific care provided to residents which was identified as deficient. If care problems continue to exist, the surveyor must assume that the facility's appraisal of its service delivery breakdown or the implementation of its plan for correction was insufficient. At this point, further action on the certification status of facilities which remain non-compliant will follow traditional procedures.

Life Safety Code Survey

As in the past, the Life Safety Code portion of the survey is performed on an onsite basis in every facility. Implementation of the new survey process will not affect the nature or requirements of a Life Safety Code survey. The Life Safety Code surveyor will continue to apply the particular edition of the code applicable to each facility, either in conjunction with or separate from the revised activities of other surveyors.

CHAPTER SEVEN

CONSUMER, INDUSTRY, AND STATE INVOLVEMENT

Introduction

Arguably the single most important ingredient in achieving the implementation of the new long-term care survey process has been the continuing cooperation among all of the primary parties in the nursing home regulatory system. As discussed in the background section of this report, HCFA laid the groundwork for a revised survey during the 1983 task force sessions of Federal, State, industry and consumer representatives to identify areas of consensus for changes in the survey and certification process and regulations (Subpart S). One issue on which all the groups could agree was the inherent shortcomings of the traditional survey process and the need to develop and test improved survey procedures and forms. Throughout the PaCS developmental and testing process, HCFA has maintained ongoing contact with representatives of the consumer advocates, the nursing home industry and the State survey agencies in order to obtain their input and support in our efforts to refine the new long-term care survey. Each of these groups was represented at the initial surveyor training sessions on the new methodology, and HCFA hopes to continue drawing on their expertise and resources as the new survey process evolves.

Consumer Advocate Role

The National Citizens' Coalition for Nursing Home Reform (NCCNHR), the National Council for Senior Citizens (NCSC), and the American Association of Retired Persons (AARP) all took part in the Subpart S workgroup sessions of 1983. Since that time, HCFA has kept these organizations apprised of progress towards a revised survey process and has worked particularly closely with NCCNHR on some of the specific details of the new methodology.

NCCNHR is designed to coordinate the activities of nearly 200 consumer advocacy groups including a national network of State and local long-term care ombudsman programs. The Coalition works to ensure that nursing home residents receive quality care and are represented in the regulatory process. During the Subpart S workgroup sessions, one of NCCNHR's primary concerns was that the proposed changes in the long-term care survey procedures did not take into consideration the information and personal experiences available from nursing home residents. In an effort to facilitate increased resident participation in the survey process, HCFA agreed to provide partial funding for a project to collect and analyze information from residents across the country about the quality of care and life in nursing homes. This project, which was funded primarily by the AARP, culminated in a National Symposium on Quality Care in February 1985.

The symposium provided a forum to present the composite findings of NCCNHR's resident discussions. Although public policy was the least discussed issue among residents, they felt strongly that they should have direct input into the nursing home inspection process. HCFA and the other parties involved in the regulatory system have come to recognize the fundamental fairness of this assertion, and mandatory resident interviews are an integral element of the new survey methodology.

In addition to propounding the need for resident participation in the survey process, the NCCNHR project also provided HCFA with guidance as to the type of questions that surveyors should ask residents about the delivery of care and services and suggested techniques to be used in questioning the resident population. Much of this information was incorporated into the procedural guidelines developed for use with the new survey process.

Since NCCNHR issued the final report on its residents' perspective project in April 1985, HCFA staff have continued to meet regularly with Coalition representatives (e.g., on May 16, August 15, September 6, October 10) to discuss the many issues involved in the refinement and implementation of the new long-term care survey process. Other consumer organizations, particularly the National Senior Citizen's Law Center and the aforementioned NCSC have also played a role in these discussions. The September 6, 1985 panel session on the proposed survey process, which took place in the larger context of NCCNHR's ninth annual meeting, provided a good example of the cooperation that has characterized the PaCS developmental process. This meeting brought together representatives from the consumer advocacy groups, the nursing home industry and the State agencies to be briefed by HCFA and to present their respective concerns.

Although the consumer advocate groups have generally been very supportive of the new survey methodology, they have expressed concern over the adequacy of the surveyor training program, especially in view of the initiation of required resident interviewing. In what constituted a true landmark in Federal/consumer cooperation, NCCNHR agreed to develop a script and enlist actual nursing home residents as role players for a video tape instructing surveyors on interviewing skills and techniques. In addition to the strengthened surveyor training program, HCFA has adopted several of NCCNHR's suggestions for inclusion in new procedural guidelines, including the recommendations that surveyors routinely obtain input from a facility's resident council and that surveyors post notice and wear identification to indicate that an inspection is being conducted. Other NCCNHR suggestions, such as required State agency contact with local ombudsman groups and resident participation in exit interviews, remain under consideration.

Following publication in the Federal Register of the proposed regulation implementing the new survey process on October 31, 1985, HCFA undertook a major mailing effort at the request of NCCNHR to ensure that affected groups were made aware of and had an opportunity to comment on the impending change. Over 400 packages, containing the new survey forms, procedural guidelines and other informational materials, were distributed to NCCNHR's member groups and State ombudsman programs. NCCNHR then convened a work session on December 9-11, 1985, attended by representatives of all the major consumer groups and ombudsman programs, to develop a response to HCFA's formal proposal to implement the modified survey process. Federal and State regulators, nursing home industry representatives and legal service professionals specializing in consumer issues also contributed their views. Most of the organizations represented at this meeting submitted formal comments to HCFA as part of the rulemaking process. A brief analysis of comments concludes this chapter.

Nursing Home Industry Role

Like the consumer advocate groups, organizations representing the nation's nursing home industry have made continuing contributions to the PaCS refinement process since its introduction at the Subpart S workgroup sessions late in 1983. Among the organizations that have taken part in this effort are the American Health Care Association (AHCA), the American College of Health Care Administrators (ACHCA), and the National Council of Health Centers (now merged with AHCA). HCFA has also received direct input on the new survey process from representatives of facility chains (e.g., Beverly Enterprises, Manor Health Care Operation), State and local provider organizations and individual facilities.

Shortly after the first pilot testing of the PaCS survey process began in December 1983, AHCA distributed copies of the earliest version of the modified survey forms to a large number of its members. AHCA reported to HCFA in February 1984 that its members found the new format to be an improvement on the traditional process, but also had an extensive list of specific suggestions for improving the forms. In June 1984, AAHA reported that its membership had a similarly favorable reaction to the new survey process. Like their AHCA counterparts, the AAHA members made numerous suggestions about additional language or clarifications that could be included in the survey form in addition to some more general concerns. For example, both groups felt that the word "resident" rather than "patient" should be used throughout the forms and guidelines, and they also expressed concern over a perceived trend towards negative wording (i.e., "patient is not groomed properly," "eating utensils are not available") in the PaCS indicators and interview questions. HCFA made substantial use of these types of recommendations in developing the subsequent versions of the new long-term care survey.

As HCFA began preparing for national testing of the modified process, the industry groups continued to play an active role. AHCA representatives attended a PACS surveyor training session in December 1984 to increase their understanding of how the new process was to be applied. ACHA then requested a meeting with HCFA staff to discuss several areas of concern about the modified survey process, including:

- Tone - AHCA felt that parts of the PaCS survey forms, particularly the sections on physical environment and dining assistance, were still worded negatively and needed to be reformulated in a more neutral tone.

- Resident Interviews - AHCA estimated that, based on the questions included in the survey forms, resident interviews could run as long as 30 minutes and include inappropriate areas of questioning for some residents.

- Norms and Standards - AHCA expressed concern that the new process would perpetuate the subjective nature of current compliance decisions unless standards and norms were established prior to implementation to define operational compliance.

HSQB staff met with an AHCA representative on January 29, 1985, to address these issues. They agreed to make the necessary further changes in the forms to assure neutrality in tone and indicated that the procedural guidelines had already been amended to include more specificity regarding the length and nature of resident interviews, based on similar suggestions from HCFA's Office of Management and Budget. Regarding the need to establish norms and standards, the HSQB staff pointed out that one of the major assets of the new survey process is that it defines a minimal data set that surveyors are required to cover during each survey. Once the new methodology is fully implemented, HCFA intends to gather baseline data in order to identify norms and standards for compliance decisions.

At a May 3 meeting of the AHCA Standards Committee, consisting primarily of representatives of nursing home chains, the group reiterated to HCFA staff its support of PaCS and acknowledged HCFA's responsiveness in removing negative language from the survey form. HCFA then contributed an article to the AHCA Journal (Vol. 11, No. 4, July 1985) discussing the objectives and features of the new process and tentative plans for implementation. During August and September 1985, HCFA staff met twice with ACHCA, the leading facility administrator organization, to keep them informed on progress towards implementing the new survey process. ACHCA was also supportive and requested a similar article on the new methodology for its own publication, which HCFA has submitted for inclusion in the ACHCA's spring 1986 issue. Another facet of the industry organizations' ongoing involvement has been their participation in NCCNHR forums such as the September 6, 1985 panel session and the December 9-11 workgroups on the proposed survey process. Both national organizations such as the AHCA, AAHA and ACHCA, as well as State and local industry groups, have been represented at these meetings.

The result of HCFA's continuing contact with the nursing home industry has been a new survey methodology that is better understood and better accepted than any previous attempt to revise the inspection system. As AHCA stated in its November 15 newsletter:

> "Providers who have been surveyed under PaCS have been impressed with the new process. They have reported that patient interviews have not been lengthy, that patient privacy has been respected and that staff members have enjoyed their role in demonstrating quality. Repeatedly, providers have said that PaCS does focus the survey process on quality." (AHCA Notes, Vol. 14, No. 21, Nov. 15, 1985, pg. 5)

AHCA's impressions were corroborated by Brown University's findings from its questionnaire on the reactions of nursing home administrators. HCFA will be soliciting provider input as the new long-term care survey implementation and evaluation process unfolds. An initial indication of this commitment to continuing consensus building was found in the first surveyor training sessions for the new methodology, which brought together Federal, State, consumer and industry representatives to experience the new training program.

Role of the State Agencies

In terms of immediate impact, the people that are most affected by the change to a new survey methodology are the State agency surveyors charged with carrying out the new methodology. With this in mind, HCFA formed a PaCS advisory committee to discuss issues related to the implementation, evaluation and refinement of the new survey process. This committee, which has been meeting on a regular basis since September 1984, consists of HCFA staff and representatives from the Association of Health Facility Licensure and Certification Directors (AHFLCD) and from the three State survey agencies involved in the formal evaluation of the PaCS process. Dr. William Spector, who headed up the Brown University evaluation effort, also attended the early meetings of the committee and submitted interim reports for review once the evaluation was underway.

The first meeting of the advisory committee took place on September 13, 1984. Representatives from Connecticut, Rhode Island, and Tennessee confirmed that the States would participate in the formal testing process, and surveyor training sessions were scheduled for October 1984. Following a discussion of the PaCS pilot testing process and the planned 1985 implementation and evaluation strategy in those three States, the AHFLCD reported a concern among its members that the PaCS process would be implemented without modification after the test was completed. HCFA responded that such a prospect was extremely unlikely in view of the wide range of consultant, consumer, industry and State input that would be forthcoming during 1985. Participants then agreed that they would meet regularly throughout the 1985 testing year, and HCFA intends to continue drawing on the AHFLCD as a source of State reactions and suggestions as the new survey process is implemented nationally in 1986.

Subsequent meetings of the advisory committee were held on December 12, 1984, and on April 2, July 12, and October 23, 1985. The first of these concentrated on the implementation activities of the three formal testing States and a discussion of the testing and evaluation strategy for the remainder of the country. The 1985 sessions of the committee normally consisted of updates on Brown's testing progress and available results, comments from Rhode Island, Connecticut and Tennessee, a national update on implementation status and findings in the other 47 States, and then a report on HCFA's activities and timeframes relating to PaCS revisions and plans for full national implementation. As an outgrowth of these meetings, HCFA also convened a PaCS form workshop to gather further feedback from State and Federal surveyors on problems encountered in using the new methodology and recommendation for forms modifications.

The purpose of the surveyor workgroup was to evaluate the design and content of the PaCS survey report forms and to devise a more workable product. Participants in the three-day (June 17-19, 1985) workgroup session included experienced PaCS surveyors from nine States and two ROs. Following a brief report on the results of Brown's questionnaire on surveyor acceptance of the new survey process and forms, the group was encouraged to focus its review and recommendation on the more problematic forms.

The surveyor workgroup demonstrated a surprising degree of consensus as to needed revisions in the PaCS forms. The group recommended that the forms covering pharmacy record review and suggested interview questions be placed in guidelines and that the tally sheet be deleted altogether. They also suggested major format revisions to the summary form and the observation/interview/record review form. These recommendations, which were generally in concert with those developed by RCC through its evaluation of the PaCS process, were adopted in the revised version of the long-term care survey instrument.

Although the State survey agencies were proving to have substantial input into the final composition of the new survey methodology, AHFLCD still had some serious reservations about HCFA's transition plans. In an August 7 letter to the Director of HSQB, AHFLCD expressed its belief that the new survey process was superior to the traditional survey but that the planned January 1986 implementation would not permit adequate time to incorporate evaluation findings and to properly train surveyors.

HCFA subsequently postponed implementation until the Spring of 1986 and held a series of surveyor training courses in the revised methodology from February through April of 1986. As detailed in the next section of this report, HCFA also provided each State with the materials necessary to train surveyors who could not be accommodated at the first set of Federal training sessions. Implementation of the new process will be accomplished on a phased-in basis, and no surveyor will be expected to conduct the new survey without prior training.

Public Comment

HCFA received approximately 75 letters of comment in response to its NPRM introducing the new survey process for nursing homes. These letters came from a multiplicity of sources including most of the national consumer and provider groups mentioned above, State survey agencies and departments on aging, professional organizations, local ombudsmen and resident advocacy groups, as well as individual providers, nursing home residents and other concerned citizens. The comments reflected widespread overall support for HCFA's efforts to refocus the survey process on the review of individual resident care.

At the same time, the majority of commentors offered strong and often conflicting suggestions as to how the new survey process (and the entire long-term care regulatory system) could be further revised to better assess and ensure quality of care in nursing homes. Among the issues drawing particular attention were the following:

- Implementation schedule
- Need to incorporate IoM study results
- Training program
- Procedural and care guidelines
- Resident sample selection methodology
- Confidentiality of resident interviews
- Need for ombudsman involvement in survey process
- Deficiency formulation criteria (i.e., need for norms and standards)
- Use of Part A of the new process
- Survey team composition
- Increased duplication between survey and IoC reviews (and the need to integrate the processes)

These comments have been reviewed by HCFA staff, and specific responses are now under formulation. The final rule will include a detailed description of comments and HCFA's responses. In general, HCFA believes that the new survey process already constitutes a significant improvement over its predecessor and is ready for implementation. As Chapter Nine of this report describes, HCFA is committed to the continuing refinement of the new methodology, with revisions expected as early as the Fall of 1986.

CHAPTER EIGHT

SURVEYOR TRAINING IN THE NEW PROCESS

Introduction

A recurring theme among the diverse list of organizations and individuals who have contributed to the development of the new survey methodology has been the overriding importance of the surveyor training program. HCFA recognizes that the success of the new process depends in large measure on how well surveyors understand the revised approach and how consistently they employ its forms and techniques. With this in mind, HCFA has developed a 3-day program to educate surveyors in the new process. The specific objectives of the training program are threefold:

- Provide surveyors with an understanding of the philosophical intent and the developmental background of the new resident-oriented survey process;
- Provide instructions and the opportunity for hands-on experience in the use of the new survey report form and accompanying worksheets; and
- Instruct surveyors in the resident interviewing and observation techniques that are the focus of the new approach.

Training Schedule

HCFA is initially conducting six training sessions on the new long-term care (LTC) survey process, with approximately 50 Federal and/or State surveyors in attendance at each session. Representatives of consumer and industry groups that have been involved in the formation of the process also participated in the initial training session held in Baltimore from February 11-13, 1986. Subsequent sessions were scheduled as follows:

Baltimore, Maryland	February 25-27
San Diego, California	March 4-6
Albany, New York	March 11-13
Chicago, Illinois	March 18-20
Denver, Colorado	March 25-27

Participants in the sessions include LTC surveyors of all disciplines as well as individuals from the States and regional offices responsible for the supervision and training of surveyors. Course faculty consist of Federal and State personnel who have taken part in the testing and refinement of the new forms and procedures, along with consultants to HCFA who are regularly involved in surveyor training.

Training Agenda

The new LTC survey training course is designed to be a participatory program. Each surveyor has an opportunity to simulate a resident-centered survey in a controlled environment through the use of audio-visual aids. The course includes presentations on the following specific areas:

- Background information on the new process
- LTC Survey Report Forms
- LTC survey guidelines
- Facility tour
- OIRR worksheet
- Drug pass observation worksheet
- Dining and eating assistance worksheet
- Formulation of deficiency statements
- Resident observation and interviewing skills

Each of the new data collection worksheets is covered in detail and used frequently. Instructors place special attention on the skills development portion of the training, emphasizing the importance of surveyor sensitivity to the rights and needs of residents.

Training Materials

The training program for the new survey process makes extensive use of audio-visual aids. These training materials serve not only to promote the increased effectiveness of the HCFA-run training sessions, but also to assure that training conducted in the individual States can incorporate a consistent approach to the new process. A brief description of each of the training aids that HCFA has commissioned is provided below:

- Introductory Video - Media Communications developed a videotape to introduce the new LTC survey process. The tape includes a brief introduction to the Medicare/Medicaid program, the intent of the regulations and their impact on residents and the nursing home industry.

- Slide/Tape Presentation - Rehabilitation Care Consultants, Inc. (RCC) produced an integrated slide/tape presentation that provides an overview of the new LTC survey process and portrays a tour of a facility depicting significant survey functions and form usage.

- Slide/Case Study Exercise - RCC also produced 40 slides covering typical nursing home problems in resident care, physical environment, eating assistance and nutrition. The slides are presented in conjunction with three short exercises demonstrating the use of the Facility Tour, Dining and Eating Assistance and Drug Pass worksheets. The slides are also integrated with a case study made up of information from two sample residents in order to demonstrate how to use the OIRR worksheet and to translate findings onto the Survey Report Form.

- Skills Development Tape - The National Citizens Coalition for Nursing Home Reform provided HCFA with a script and actual residents to serve as role players for a video tape on interviewing. The tape focuses on increasing surveyor sensitivity to the rights, needs, and dignity of nursing home resident, in conjunction with the implementation of required residents interviewing as part of the new survey process.

- o Course Manuals - HCFA developed a training manual incorporating all the written materials necessary to accompany the audio-visual training aids described above, including:
  - orientation material
  - survey report forms
  - procedural guidelines
  - care guidelines
  - case study materials

Extended Training

Since the intial training sessions can accommodate only about 300 of the approximately 2,000 LTC facility surveyors, HCFA needed to find a way to rapidly orient the remaining surveyors so that the new methodology can be nationally implemented on a timely basis. Resource and time constraints preclude the immediate retraining of all surveyors through central office run training sessions. Instead, HCFA has developed a self-contained training module based on the audio-visual materials used at the initial training sessions. Regional and State surveyors who attend the HCFA-run training are using these materials, in conjunction with the training course manuals, to familiarize all surveyors in their respective areas with the new process. Over 500 of the manuals are being made available to all the HCFA regional offices and the State survey agencies for further duplication and distribution to each nursing home surveyor.

In one sense, development of a new survey process represented an attempt to formally embody the preferred techniques (e.g., emphasizing individual resident observations, resident and staff interviewing) that have always been used by many surveyors. The phased-in implementation process that is about to begin will assure that all surveyors will be using these techniques in the field as soon as possible, thus providing immediate practical reinforcement in the use of the new process. This is in line with RCC's recommendation that there be a minimal time lag between surveyor training and actual implementation. HCFA will also provide follow-up training in late 1986 and early 1987 in order to maintain consistency in the application of the new survey process. Specific areas to be stressed will be identified through Brown University's evaluation of sample surveys during 1986, an internal evaluation of the initial training process and the continuing use of surveyor questionnaires on the new process.

CHAPTER NINE

FUTURE PLANS: THE EVOLUTION OF THE SURVEY PROCESS

Introduction

The new long-term care survey process to be introduced by HCFA, in the Spring of 1986, represents the first major substantive change in the method used to assess nursing homes since the inception of facility surveys in the late 1960's. Although national implementation of the new survey process is a meaningful milestone in Federal quality assurance, it is by no means viewed as an cure-all. Rather, the new survey methodology constitutes the beginning of an evolving process of assuring that nursing home surveys employ state-of-the-art techniques for assessing the actual quality and outcomes of care provided to facility residents.

Beyond this, HCFA recognizes that the survey process does not take place in a vacuum, but needs to be considered in the larger context of the entire Federal quality assurance, enforcement and even reimbursement role. The new process has been designed to accommodate and complement several anticipated initiatives springing from recommendations of the Institute of Medicine's (IoM) Study of Nursing Home Regulation as well as the possible future implementation of a national prospective payment system for nursing home reimbursement. The concluding section of the report outlines HCFA's short- and long-term plans for the continuing evaluation and refinement of the survey process and how the evolving process fits into the overall regulatory system.

Short-Term Agenda

In order to assure that the survey process continues to evolve as planned, HCFA plans to conduct ongoing reappraisals of the new process and then to initiate appropriate changes at pre-determined intervals. The Fall of 1986 will mark the first such interval.

As part of this effort, HCFA is already involved in several initiatives to refine the new survey methodology and/or the accompanying guidelines. A brief description of each of these initiatives, all of which are now in the developmental stages, is presented below:

o Revised Care Guidelines--During the rulemaking process used to introduce the new survey process, representatives of both the consumer advocacy groups and the nursing home industry organizations expressed a willingness to assist HCFA in further refining the care guidelines used by surveyors to assess the quality of care provided for a specific problem or condition (e.g., contractures, decubiti, etc.). HCFA will utilize health professionals, drawn from the Federal, consumer and industry sectors and working in a group format, to make suggestions for refinements in the current guidelines in time for implementation in the Fall of 1986.

- Resident Sample Selection Methodology--Although the evaluations of the alternative State survey methodologies cited the need to select a resident sample that targeted potential problem areas, comments on the NPRM evidenced some concern that such targeting might give a distorted view of a facility's care provision performance. In response to such comments, HCFA made a number of changes to its procedural guidelines to emphasize how surveyors can be sure to select a representative sample of residents for in-depth review. Additionally, HCFA staff are now in the process of developing a more detailed sample selection methodology that will instruct surveyors in the selection of targeted residents within random-stratified categories. This process is also anticipated for implementation in the Fall of 1986.

- Ombudsman Involvement in the Survey Process--In conjunction with requiring resident interviews and resident council input into the survey process for the first time, HCFA also recognizes the contribution that local resident advocacy groups, particularly ombudsman programs, can make to the survey process. HCFA will convene a forum of its own central and regional office staff, State personnel, and representatives of the NCCNHR and its regional/local member organizations to identify model sites for review of current notification, consultation, and information sharing practices. Based on this review, HCFA plans to issue an advisory policy in the Fall of 1986 on State agency linkage with regional and local ombudsman groups and/or other resident advocates.

- Survey Team Size and Composition Study--HCFA is currently collecting data regarding size and composition (including qualifications) of survey teams as they vary across States. This data will be compared with State deficiency findings in a effort to develop parameters for what constitutes a "model" survey team for each provider type. HCFA plans to work with State survey agency representatives in developing the model team recommendations. The long-range possibility exists that States may be funded at levels based on such staff support needs.

In addition to these activities, several forces are, or will be, at work that may result in further changes to the new survey process as early as the Fall of 1986. Foremost among such forces is the IoM study, the results of which are expected to be available by March 1986. Although the study is directed primarily at long-range policy alternatives for nursing home quality assurance, HCFA will begin to implement acceptable recommendations as soon as feasible. In fact, preliminary indications are that both the involvement of ombudsman groups and the use of stratified random sampling in surveys will be among the IoM recommendations that can be accomplished on a short-term basis. Other sources of information that can contribute to the initial refinement of the new survey process include the final results of Brown University's evaluation of the formal PaCS testing, the Federal monitoring survey results, as well as State and regional surveyor input on both the new training program and the effectiveness and ease of implementation of the new process as used in FY 1986. These sources are also expected to be used by HCFA to identify areas to focus on during the second round of training sessions slated to begin in the fall of 1986.

Long-Term Agenda

As mentioned, the IoM study is expected to be a significant source of recommendations that can be used to help set long-term goals for the refinement of the survey process and the overall nursing home regulatory system. During 1986, HCFA will prepare a comprehensive response to the IoM proposals delineating how HCFA plans to address specific study recommendations. The majority of HCFA's long-term agenda, however, will be determined by the results of a series of studies aimed at refining the new survey process and investigating its potential for providing individual resident assessment information. These studies include:

1. Effectiveness of New Long-Term Care Survey Process--HCFA's Health Standards and Quality Bureau has awarded a 2-year contract (January 1986 to December 1987) to the Long-Term Care Gerontology Center at Brown University to extend its evaluation of the new survey process. This contract will study and report on the following:

   - Use of Norms and Standards for Deficiency Citation--Through an in-depth analysis of all data from its three-State formal evaluation, Brown will examine the relationship between numbers and types of negative findings and deficiency citations. This analysis will be presented to the State Survey Directors in six New England States (HCFA's Region I) in order for them to develop a consensus on what are appropriate criteria for deficiency citations. Once a consensus has been achieved, the next step will be a trial implementation of the standards in Region I, leading to eventual national introduction of norms and standards for what constitutes a deficiency.

   - Effective Use of New Procedures by Surveyors--Brown University personnel will observe a sample of surveys in five States (New York, South Carolina, Missouri, Wisconsin, California) during 1986 to determine how consistently surveyors are implementing the new methodology, to identify specific difficulties surveyors may be experiencing, and to collect information on how much time is involved and how time is allocated under the new process. This portion of the study will result in recommended refinements to both the survey process and the surveyor training program and provide baseline time data for future comparison.

   - Effectiveness of Enforcement Mechanisms Following the New Survey Process-- Using the same five States as testing sites, Brown personnel will conduct site visits to a sample of facilities after State surveyor follow-up visits. They will make independent determinations as to whether deficiency correction plans have been met and whether surveyors have properly documented any lack of correction. Brown will also perform a qualitative review of each State's enforcement mechanisms and a quantitative review of the number and type of enforcement actions taken. This portion of the study should produce strengthened Federal guidelines on follow-up and enforcement activities.

2. Longitudinal Study of Case-Mix Outcomes and Resource Use in Nursing Homes--Under the direction of HCFA's Office of Research and Demonstrations, Brown University is conducting a separate 3-year study (October 1985 - September 1988) to identify relationships between resource use and resident outcomes over time. The project involves first the development of case-mix subgroups for nursing home residents, the tracking of outcome patterns for these subgroups and finally the formulation of appropriate resource use patterns for the case-mix categories. In terms of the survey process, findings from this study can provide standards for surveyors to determine if sufficient staffing and other resources are available to care for the specific needs of residents in each facility. The project also has major implications for linking HCFA's quality assurance and reimbursement mechanisms.

3. New York State Survey/IoC and Reimbursement Demonstration--ORD is now strongly considering approving a New York proposal for a 3-year demonstration (beginning in November 1986) linking the new survey process, New York's Sentinel Health Event IoC system and its new case-mix reimbursement system. The New York system will provide a working laboratory for examining how a prospective reimbursement system in nursing homes will impact on quality of care, as measured by the new survey process and an integrated IoC review. The proposed system will also be the first test of the use of a pre-selected random stratified resident sample and of an early warning system to target facilities for unannounced off-cycle surveys that have high incidences of poor outcomes and/or too few staff.

4. Multi-State Demonstration Integrating Case-Mix Reimbursement and Nursing Home Quality Assurance Systems--ORD is now in the process of organizing a 5-State, 5-year study (tentatively beginning in December 1986) to examine whether data obtained through a case-mix reimbursement system can be used to monitor individual resident care and the overall quality of care of individual nursing homes. Such data would also be used to test the desirability of a targeted approach to long-term care survey and certification activities, i.e., focusing monitoring activities on certain providers and thus reducing overall nursing home surveillance costs. While New York would be among the five States, the demonstration would need to take place in a sufficient number of States to assure the applicability of findings despite extensive inter-State variations in the nursing home industry.

New Directions

Even a cursory review of these studies reveals a significant new direction for the survey process towards the collection of resident specific data to supplement the traditional facility deficiency data.

During the 1985 formal PaCS demonstration, it will be recalled that surveyors in Rhode Island were required to calculate ADL assessments for all sample residents and to record all resident assessment information via the use of portable computers. These procedures, although not imminent for national application, represent the wave of the future in long-term care surveying. HCFA envisions that surveyors will eventually input both facility-specific and resident-specific data directly into its automated data system.

The collection of individual resident assessment information on a sample basis is a precursor to a long-awaited change in the nursing home quality assurance system--the integration of the survey and IoC processes on a national basis. Over the past several years, the many advantages of survey/IoC integration have been repeatedly documented in both internal HCFA studies as well as a series of studies such as the Mathematica and RCC reports and individual State assessments. The forthcoming IoM report will also strongly support integration. Since the new survey process essentially follows an IoC review approach to the resident sample, even more duplication between survey and IoC review will take place. If resident-specific sampling based on outcome measures continues to prove viable and effective, both Congress and individual States are likely to recognize that the new survey process negates the need for the prohibitively time consuming IoC review of 100 percent of facility residents.

Finally, if the advent of resident specific assessments can facilitate the transition to an integrated survey/IoC review system, such assessments are an absolute prerequisite to HCFA's plans to propose a prospective payment reimbursement system for nursing homes, as required by Congress under the Tax Equity and Financial Responsibility Act of 1982 (P.L. 97-248). The new survey process, with its increased emphasis on in-depth resident assessment and its potential for providing outcome and resource utilization data, looms as the logical vehicle for collection of the data that will be essential to assuring that nursing home quality of care does not suffer under a prospective reimbursement system.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Region X
M/S 409
2901 Third Avenue
Seattle, WA 98121

March 5, 1986

Sharon Morrison, Manager
Bureau of Nursing Home Affairs
Department of Social and Health Services
623 8th Ave. S.E. M/S HB-11
Olympia, Washington 98504

Dear Ms. Morrison:

The HSQB central office has completed its training on the Long Term Care Survey Procedure (LTCSP). It is now time to commence training the remaining long term care surveyors and regional office staff on this procedure.

We will proceed per our agreement at the State Agency Directors/Division of Health Standards and Quality meeting of December 1985. Two surveyors from your state will meet with RO and other SA surveyors and design the LTCSP training package for all of the states. RO staff will also participate in this training effort. This meeting is scheduled for **March** 17 and 18 in Room 180 of our building. 10AM.

In accordance with the terms of the 1864 agreement between the Department of Health and Human Services and the State, we are requiring that these individuals attend the training. Your **Medicare and Medicaid Program budgets should be charged for the expenses incurred for attending this course.**

The LTCSP training for your state will take place during the week of April 14th. Questions concerning this training can be directed to Roger Monson on (206) 442-4151 or me on (206) 442-8162.

Sincerely,

Ronald L. Hansen
Ronald L. Hansen, Director
Survey and Certification Program
Division of Health Standards and Quality

[MAR 06 1986]

MAR 0 6 1986

[FM:] Director
Division of Systems, HSQB

[RE:] Comments: OIG Draft Audit Report - Use of the Medicare/Medicaid Automated Certification System—MMACS (ACN 03-60154)

[TO:] Henry W. Kretschmaier, Jr., Director
Office of Program Support, HSQB

We have reviewed the subject report and have the following observations and comments about its contents:

A. Observations:

1. Since the real thrust of this audit attempts to address the problems that HSQB is currently experiencing in its continuing efforts to effectively administer the survey/certification process (through their counterparts in the regions, at the regional office level and their respective State survey agencies) it would be more appropriate to title this audit report "Management of the Survey and Certification Process." A correlation for this report would be attacking your calculator when your checkbook doesn't balance.

2. The conclusion that "MMACS IS NOT AN EFFECTIVE TOOL ...." appears to be flawed and invalid. Throughout this report, references are made to the use of MMACS as a source of data, for example—

   -As of January 1, 1985, MMACS indicated that there were 3,849 LTC facilities that had not been surveyed in 15 months. A hardcopy review of 1,568 of these 3,849 LTC facilities indicated that 1,506 (96 percent) had in fact been surveyed, but not entered into MMACS.

   This use of MMACS data to determine that the survey/certification process (which includes mandated support of MMACS) was not being completed on a timely basis by the State survey agencies, and that the resulting data from those surveys were not being entered into MMACS on a timely basis, more appropriately supports the conclusion that the survey/certification process is not being managed and/or supported properly, rather than a systems problem.

This alternative conclusion is also supported by the expressed views/perceptions of regional officials who charge that MMACS is outdated, inaccurate, and unreliable. They criticize the effect when they are the cause. One can only come to the conclusion that the regional staff is shooting themselves in the foot, since they are responsible for timeliness and accuracy of the data.

3. Our evaluation (March 13, 1985) that MMACS original requirements/objectives were still valid and being satisfied efficiently, was an overall assessment of MMACS' capabilities. Even though there were some data support problems in some of the regional offices at that time, they were not significant enough to undermine the overall effectiveness of the system. After all, the majority does rule. The report has only evaluated data for four (4) out of eighteen (18) categories of providers that make up the MMACS data base, and in fact, represent less than 50 percent of the total MMACS universe. In addition, as bad as the statistics are on LTC facilities, the problem universe is less than 25 percent of the total LTC facility universe.

   Based on our day-to-day operations, MMACS is, and has been very up-to-date, accurate, and reliable in at least 50-60 percent of the regional offices (with the possible exception of a bad State here and there), with the remaining 40 percent effectively ignoring their mandate to support the MMACS.

B. Comments

1. We are in full agreement, at least in principle, with the reports' recommendations--necessary actions must be taken and enforced, that will bring the survey/certification process and MMACS to a current, accurate, and reliable level of systems operation. But, we disagree with the need to create a "National Strategy" if they refer to a MMACS systems capability.

   MMACS could have provided, at the time of the audit, all of the problem States (and regional offices) that are in need of more special attention than the national trend. In fact, if the study area was limited to just two (2) regional offices, they would have:

   - been exposed to approximately 66 percent (66%) of all facilities contained in the ten (10) States with the largest number of facilities not certified, and

   - been exposed to just under 50 percent (50%) of all the facilities identified as out of compliance as of January, 1985.

2. There is an underlying problem in the survey and certification process that has a direct effect on the timely processing of surveys by the S/A's/RO's and the input of the related data into MMACS. This problem concerns the lack of any HSQB line control on reporting by its regional office counterparts, which is a by-product of the autonomy that was granted to the RA's some years back.

   In light of the fact that what we are dealing with is good will, if we don't have it with a particular regional office, it is difficult to get that RA or ARA to be responsive to the needs of OSC, including MMACS. For example: the report recommends establishing a time frame for the input of survey results into MMACS. They are, in fact, already bound by the Disclosure of Information to complete the entire survey/certification process (which includes MMACS) in 90 days, but, without their good will, it is not being done.

   This autonomy situation, and the fact that at the time of OBRA reductions, we were not as responsive as the regions thought we should have been, nor did we come out with real solid direction on how to proceed after the budget cuts. They formed an opinion that we left them out there to do the best they could on their own, and they did. What they need is firm guidance with appropriate follow-up for regions which do not adhere to reporting standards.

A system is only as good as the management and people who operate the system. This audit report reconfirms this philosophy. Most of these problems are old problems which the management system must solve, not the computer system.

Donald C. Sikora

HCFA/HSQB/OPS/DCS/BBlock:cp 3/4/86
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File Code ______

A. N. SHINPOCH
Secretary

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Olympia, Washington 98504-0095

March 10, 1986

Thomas G. Wallner
Associate Regional Administrator
Division of Health Standards and Quality
HHHS/HCFA
Region X MS 409
2901 Third Avenue
Seattle, Washington 98121

Dear Mr. Wallner:

This letter responds to your request pertaining to the Bureau's Comprehensive Evaluation Report received January 30, 1986. The two action items are addressed as follows:

ACTION ITEM 2 requires Life Safety Code (LSC) surveys to be conducted within 60 days before or after the health survey. The Bureau and the State Fire Marshal's Office are in receipt of your November 4, 1985 State Letter 181 which relayed the procedural change. Meetings have been held with the State Fire Marshal's Office and scheduled visits are being adjusted accordingly. Revised schedules should be completed April 1986. The WASH-SPIN computer information for health and Life Safety Code is being programmed to adhere to maintain the 60-day requirement.

The November letter moved further in the direction of reducing advance notification of the survey visit and fire marshal visit based on the State Operations Manual procedure of thirty days. The Bureau continues to be concerned that the policy or practice should not serve to announce the survey visit. We believe that 90 days prior to the health survey and 30 days following would provide added management flexibility and better preserve the element of surprise. Please consider this letter a request to adjust the schedules, to permit increased program effectiveness.

ACTION ITEM 4 requires implementation of Time Limited Agreements (TLA) in addition to annual survey cycles. When the Bureau implemented open ended contracts and established survey cycles, the equivalent of one FTE was eliminated. The budget does not have funds to re-establish Time Limited Agreements and to do the increased required paperwork. Requiring TLA's of all homes is a non-productive expenditure of scarce public resources. It takes both federal and state staff away from field work to do paperwork. A fundemental problem caused by Time Limited Agreements is the loss of flexibility of the survey agency at increased costs. Open-ended periods allows continued certification until there is a necessary adverse action to terminate it. The contract that the state enters into with the provider contains a clause that either party can terminate with 30 day written notice; the ultimate effect is that we do have a time limitation on the agreement when appropriate. Hospitals have successfully operated with open-ended agreements since 1965 when they initially entered the program. The nursing home rules and regulations have been demonstrated to be more stringent than those for hospitals.

Under the open-ended contract, the state can establish a provider's survey frequency based upon the degree of compliance achieved, compliance history, history of complaints, Inspection of Care findings, stability of key staff, and history of adequacy of corrective action. In other words, the state has the flexibility to be truly responsive to the situation. The "good" providers do not need to be surveyed as frequently as the "marginal" providers.

Each provider receives an annual survey; however, when it occurs and how often is based on compliance. The providers with problems are the ones that need close, frequent monitoring. Under the open-ended contract, the state can utilize its survey resources efficiently and effectively. This permits frequent monitoring to the ultimate end that the patients' health and safety are protected.

In contrast, under Time Limited Agreements, each provider is seen on a predetermined schedule regardless of how well or how poorly they comply with the regulations. The provider knows approximately when to expect the survey. Limited surveyor resources are depleted as there is no flexibility allowed in the survey schedule. The patients in the marginal homes are not adequately protected. This is a costly, inefficient, and ineffective system.

Using an open-ended contract, the only action needed is termination. It can be used at any time the facility is found to be in noncompliance. It is not tied to any time frame during the periods of the agreement nor is it tied to an automatic cancellation clause, both of which can be readily predicted by the provider.

Any survey generated by complaints can be used to initiate a termination action when the provider is operating under and open-ended contract.

Serious complaints found to be valid can be used to generate a full survey and termination when warranted. Providers which have the poorest performance history also have the shortest survey cycles and, thereby, receive the most attention, until such time as their record reveals their performance warrants a longer survey cycle.

The same level of preparation, i.e., documentation/justification, is necessary for all three types of action: termination, non-renewal and cancellation; therefore nothing is gained by using non-renewal or cancellation procedures. Conversely, use of cancellation and non-renewal procedures serve only to duplicate what we already use in the termination procedures.

Public Law 97-35 permitted open-ended contracts and 42 CFR 489.15-16 and CFR 442.15-16 should be revised to permit open-ended or time limited agreements. The most important issue is the final result, achieved without added paperwork and increased costs to both the state and federal governments.

Washington State's experience with automatic cancellation clauses found that implementation of this provision resulted in a legal finding that due process, legal requirements still apply. There is nothing "automatic" about the concept. The automatic cancellation clause concept was not successful in the hearing arena nor in the courts.

In addition, implementation of Time Limited Agreements would appear to be in conflict with flexibility for the state fire marshal visit flexibility and demonstrates additional rationale for optional use of Time Limited Agreements or open-ended contracts. (See attached example)

As you know, the Institute of Medicine (IOM) a part of the National Academy of Sciences, is completing a 2-year study of Nursing Home Survey and Certification Process. The IOM report is scheduled to be released on March 19, 1986. Mr. James Conrad, of the Health Care Financing Administration, (HCFA) at the Termination Procedures Workshop, stated the Academy's report is in agreement with eliminating TLAs and will be recommending that mandatory TLAs for all nursing homes be discontinued.

In view of the IOM recommendation, we would appreciate a reconsideration of our waiver request. In the meantime, the Bureau is utilizing TLAs for homes with negative enforcement sanction, nursing homes participating in Medicare T-18 and open ended contracts for T-19 nursing homes, which meet conditions of participation.

If you disire additional information or we may be of assistance, please call Sharon Morrison or me. We look forward to hearing from you.

Yours truly,

Conrad Thompson

Conrad Thompson, Director
Bureau of Nursing Home Affairs
HB-11

Attachment

cc: Sharon L. Morrison
Peggy Brown
Jerry Reilly

bcc: Thelma Struck
Jerry Jarrell
Jerry Bryant
Dick Yerian
Elma Holder
Jean Schoonover
Dana Petrowsky
Charlie Reed
NHAC Members
Norm Taylor
Ray Smith
Bob DiCenso
Patrica Nemore

BNHA
February 20, 1986

SHOWN BELOW ARE THE TIMEFRAMES FOR SURVEY AND PACKET PROCESSING REQUIRED BY FEDERAL REGULATION AND STATE OPERATION MANUAL SECTIONS WHEN WE IMPLEMENT TIME-LIMITED AGREEMENTS FOR ALL XVIII AND XIX PROVIDERS.

*NOTE: **THE RN,RS, AND LSC SURVEY MUST ALL BE DONE IN THIS WINDOW WITH THE RN & RS < 2 WEEKS APART**

CERT EXPIRE DATE (X)	EARLIEST POSSIBLE SURVEY DATE (X-120)		LATEST POSSIBLE SURVEY DATE (X-75)	DATE XIX KIT TO OLY (X-65)	DATE XVIII KIT TO REG X FROM ZONE (X-45) *AND* <45 DAYS AFTER EXIT	18 OR 19: TOTAL KIT TO REG X DATE (X-45) *AND* <45 DAYS AFTER EXIT
	(THE SURVEY WINDOW)					
JAN 31	OCT 03	TO	NOV 16	NOV 26	DEC 16	DEC 16
FEB 28	NOV 01	TO	DEC 16	DEC 26	JAN 15	JAN 15
MAR 31	DEC 01	TO	JAN 15	JAN 25	FEB 14	FEB 14
APR 30	JAN 01	TO	FEB 14	FEB 24	MAR 16	MAR 16
MAY 31	JAN 31	TO	MAR 17	MAR 27	APR 16	APR 16
JUN 30	MAR 02	TO	APR 16	APR 26	MAY 16	MAY 16
JUL 31	APR 02	TO	MAY 17	MAY 27	JUN 16	JUN 16
AUG 31	MAY 03	TO	JUN 17	JUN 27	JUL 17	JUL 17
SEP 30	JUN 02	TO	JUL 17	JUL 27	AUG 16	AUG 16
OCT 31	JUL 03	TO	AUG 17	AUG 27	SEP 16	SEP 16
NOV 30	AUG 02	TO	SEP 16	SEP 26	OCT 16	OCT 16
DEC 31	SEP 02	TO	OCT 17	OCT 27	NOV 16	NOV 16

THE ABOVE IS TAKEN FROM REGS, HSQB LETTERS & SOM AND IS FIGURED AS SHOWN ON THE DIAGRAM BELOW:

```
120                 75      65            45            CONTRACT
DAYS               DAYS    DAYS          DAYS          EXPIRATION
|<--------------->|<----->|<----------->|<---------------->|
|                 |(minimum|            |                  |
|(we have 45 days |10 days |(20 days for |(45 days for feds |
|to do full survey)|for zone|SLM to review|to receive and do |
|(RN,RS, & LSC !!) |process)|sign, & mail) |their processing) |
```

*REMEMBER: ALL TIMEFRAMES INCLUDE TIME IN THE MAIL SYSTEM !!!!!

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date [MAR 12 1986]

From Director
Health Standards and Quality Bureau

Subject OIG Draft Audit Report - Use of the Medicare/Medicaid Automated Certification System (ACN 03-60154)

To John Spiegel, Acting Director
Office of Executive Operations

Attached are our comments on the draft audit report.

If your staff requires additional information, please have them contact Michael Moran on extension 47940.

Philip Nathanson

Attachment

Comments on the OIG Draft Audit Report - Use of the Medicare/Medicaid Automated Certification System (MMACS)

General

We agree with the OIG audit report that MMACS information should be kept current and accurate. The report contains a number of useful findings, and we intend to use the report as part of our effort to improve MMACS. Following are our comments regarding the specific sections of the report.

MMACS - Designed to be an Effective Management Tool

We do not know where the OIG obtained the 2 million dollar figure cited in this section. According to the Departmental evaluation of the system in 1985, the total annual operating cost of the Medicare/Medicaid Automated Certification Network is less than $900,000.

Scope of Audit

We have no comments on this section.

MMACS is not an Effective Management Tool for Monitoring Long-Term Care Facilities

We do not agree with the conclusion that MMACS is not being used as an effective management tool for monitoring State survey and certification activities. We are continually striving to improve the accuracy and timeliness of the data. Following are some of the steps we have taken toward that end:

- SA Direct Data Entry

  As the OIG findings indicate, delays can occur from the time the survey takes place to when the results are forwarded to the regional offices for review and data entry. To eliminate unnecessary paperflow and facilitate timely data entry, we began a pilot project in 1984 in four States to test the feasibility of transferring the responsibility for data entry from the regions to the States. The demonstration has been successful and we plan to increase the number of participating States this year. We expect that all States will be entering the data directly into MMACS within two years.

- Front End Data Entry

  In March 1985, we made an important change in how certification kits were processed in the regions. We now require the regions to enter all recertifications into MMACS upon receipt in the regional offices prior to review by the certification specialists. (We refer to this process as "front-end data entry".) Computer-based flags screen the recertification cases and identify facilities requiring professional review. These flags consist of certain critical requirements including Conditions of Participation which, if not met, will identify problematic facilities. The "flagged" facilities are then reviewed by the professional staff. Unflagged cases require no professional review after entry into MMACS. Because the cases are being entered into MMACS as soon as they are received in the ROs, the lag time in entering certifications into MMACS has been significantly reduced.

- Case Control System

  In conjunction with the "front-end data entry process", we developed a standardized MMACS-based case control system in September 1985. These tables provide central and regional office management with important information for monitoring certification activity and identifying processing bottlenecks. In addition to providing summary data on the number of recertification cases that are received, cleared, pending in the regions, and pending over 30 days in the regions, the case control reports also identify cases that are due from the States. This last report enables the regions to identify any recertification cases that have not been forwarded by the States within the prescribed timeframes.

- Survey and Certification Operations Report (SCOR)

  In July, 1985 we issued the first in a continuing series of quarterly reports to the Regional Administrators and top level HCFA management on certification activities in the ROs. The SCOR focuses on various aspects of certification activity each quarter using MMACS as its primary data source. Through the SCOR we have been alerting the regional offices to excessive processing times, processing bottlenecks, and improper processing and/or certification procedures. When significant problems are uncovered through analysis of SCOR (i.e. MMACS data), followup memoranda are sent to the ROs outlining the problem and recommending specific actions to be taken.

- Adverse Action Extract, HCFA-462

  Recently, we developed a new form (HCFA-462) to ensure the prompt processing of certification actions where there is the potential for adverse action (terminations and denials of payments for new admissions (alternative sanctions)). The pertinent information from the form will be entered into MMACS, and based on our analyses of the data, if the State agencies or regional offices fail to process these actions in accordance with manualized processing time limits, their failure will be documented and brought to their attention during the State and RO evaluation programs.

- Future MMACS Enchancements

  Over the next few years, we plan to expand and upgrade the MMACS to be a more effective and efficient state-of-the-art management information system. Our plans include modifying the data base to capture more patient specific information and less statistical and deficiency related information. We will focus our attention on outcomes of patient care rather than on facility compliance with the traditional structure and process.

  Another way we plan to enhance the data system is to streamline the data collection and entry techniques. As mentioned previously, within two years we expect all the States to be entering the survey results directly into the data base instead of forwarding the hard copies to the regional offices for review and data entry. Our ultimate goal is to have a "paperless process" in which surveyors will use hand-held computers to collect information about a facility, its patients and its compliance and then transmit the data telephonically to the States and regions.

We would like to emphasize that MMACS is being continuously used by the Health Standards and Quality Bureau (HSQB) to evaluate RO performance. In fact, MMACS data along with other information available in HSQB will be used this year to evaluate the majority of ROs. Additionally, we are developing a computerized State Agency Evaluation Program, to evaluate each State agency's performance under the revised Section 1864 Agreement. This process, when implemented, will rely heavily on MMACS data.

In addition, although this section of the report indicates that results of facility surveys are not entered into MMACS timely, this is contrary to what we observed during our evaluation of all the regional offices (Division of Health Standards and Quality (DHSQ)) in mid-1985. In the course of these reviews, we did find that in two regional offices there was a relatively small backlog. However, in both cases the ROs were taking steps to eliminate their backlogs.

Moreover, we found that the ROs use MMACS data, not only in evaluating State agency (SA) processing times, but in the review of a facility's past compliance history. Although some RO staff have not universally accepted MMACS, we believe that the system is being used to monitor the SAs and providers.

MMACS Shows Thousands of Long-Term Care Facilities As Not Being Surveyed Within 15 Months

We agree that long-term care facilities must be surveyed annually and we rigorously enforce this requirement. There is a strong possibility that OIG staff misinterpreted some MMACS data. To illustrate, consider the following example. The facility was surveyed in September 1984 and issued an agreement which began on January 1, 1985 and expired on December 31, 1985. The SA resurveyed the facility in November, 1985 and forwarded its certification to the RO within the required 45 days. The RO received the certification on December 21, 1985, but because of the holiday, the kit is not entered until January 4, 1986. Review of MMACS 15 months after the September 1984 survey, would not have revealed a survey as having been completed. In this case, the survey could have been even later, had the SA requested from the RO a two month extension.

In addition, some further distinction must be made between Medicare certifications and Medicaid-only certifications. Medicaid certifications are not approved by the RO. Therefore, the certification data is not entered until the information is received from the Medicaid State agency, which may be 120 to 150 days after the date of survey. There is no requirement that SAs must forward Medicaid certifications to the ROs within 45 days, since RO approval of the certification is not required.

In addition, the data on work processing times from the statistical sample of 230 surveys cited in this section was interesting because it differs significantly from a similar analysis we have done, on the same subject. The statistical sample in the OIG report reflected an average processing time of 107 days from survey date to entry into MMACS. Results of our analysis (see Attachments 1 - 3 from SCOR report dated 02/04/86) indicate the average processing times of all Medicare and Medicare/Medicaid Skilled Nursing Facilities is significantly lower than the sample findings:

Overall average processing time - 71.89 days

Average number of days between survey date and SA review signoff - 45.97 days

Average number of days between RO receipt and RO approval - 15.85 days

(Note - Since 10/85, the majority of recertifications (i.e. unflagged cases) are entered into MMACS on the same day the RO approves them).

Our analysis indicates that the OIG conclusion is grossly in error and the SAs are operating within the timeframes set forth in the State Operations Manual.

HCFA Recognizes Need to Monitor Survey Activities but Review Methods Need Improvement

The Divisions of Financial Management in the regional offices were asked to validate that annual surveys were being conducted. While the sampling technique is arguable, it must be pointed-out that this review was in addition to monitoring done on all States by the DHSQ-ROs.

Disallowance Actions Should Begin Earlier

The DHSQ-ROs were instructed to reinstitute annual surveys as early as January, 1983. In 1984, however, we found there was still some misunderstanding among some of the ROs and SAs. Therefore, in August 1984, we again clarified that annual surveys were to be instituted forthwith. We agree that all long-term care facilities should have been surveyed between October 1, 1984 and September 30, 1985 and would support disallowances of Federal financial participation to the States for facilities not surveyed during and after fiscal year 1985. Our onsite reviews of the ROs last year confirmed that the ROs are requiring annual surveys.

[COMMITTEE STAFF NOTE: Bracketted figures below are for improved legibility.]

ATTACHMENT 1

■ Highest Processing Time (Per Facility Type)

▢ Lowest Processing Time (Per Facility Type)

AVERAGE NUMBER OF DAYS
BETWEEN SURVEY DATE AND RO APPROVAL
CY 85

R = Red B = Blue	U.S.	REGION I	REGION II	REGION III	REGION IV	REGION V	REGION VI	REGION VII	REGION VIII	REGION IX	REGION X
18 & 18/19 SNFs	71.89	91.39	89.53	69.30	63.48	78.00	105.68 [105.68]	62.01	57.53 [57.53]	57.59	63.14 [63.14]
19 Only 1/ SNFs	63.51	70.18	[104.13]	54.35	65.55	62.48	59.29	75.01	59.04	59.43	36.79
ICFs 1/	63.73	55.74	[95.48]	60.47	59.15	85.32	48.32	52.75	45.78 [45.78]	57.41	67.95
ICFs/MR 1/	78.55	70.00	[114.98]	68.81	67.98	65.96	78.81	74.93	80.06	62.93 [62.93]	67.45
Accredited Hospitals	51.96	80.66	48.55	62.76	41.92	56.50	[89.44]	34.22 [34.22]	45.42	43.24	38.09
Unaccredited hospitals	86.36	96.88	[119.50]	115.81	74.86	83.27	119.25	64.51 [64.51]	65.25	84.54	80.37
LABs	61.11	80.15	[103.09]	66.14	53.11	56.08	71.73	38.39 [38.39]	41.80	47.31	44.52
HHAs	56.14	67.81	77.87 [77.87]	47.20	47.65	60.22	65.61	43.71	39.98 [39.98]	60.11	64.19

SOURCE: HMACS data current as of 01/07/86
1/ Average Number of Days between Survey Date and Single State Agency Sign Off

ATTACHMENT 2

■ Highest Processing Time (Per Facility Type)

☐ Lowest Processing Time (Per Facility Type)

AVERAGE NUMBER OF DAYS
BETWEEN SURVEY DATE AND SA REVIEW SIGNOFF
CY 85

R = Red B = Blue	U.S.	REGION I	REGION II	REGION III	REGION IV	REGION V	REGION VI	REGION VII	REGION VIII	REGION IX	REGION X
18 & 18/19 SNFs	45.97	50.04	52.61	43.24	42.57	57.36 [57.36]	50.39	49.05	42.93	B 31.73 [31.73]	35.03
19 Only SNFs	49.02	56.54	73.35 [73.35]	38.84	49.98	49.65	48.69	54.13	49.60	34.05	B 30.11 [30.11]
ICFs	46.85	45.44	58.42	45.19	46.95	59.63 [59.63]	34.60	43.21	40.81	B 30.83 [30.83]	50.[illegible]
ICFs/MR	54.77	46.83	66.10	47.45	50.10	53.07	55.18	67.16	74.31 [74.31]	B 29.34 [29.34]	61.07
Accredited hospitals	30.09	35.08	25.58	B 22.01 [22.01]	25.34	37.80	42.44 [42.44]	24.85	37.17	25.84	22.22
Unaccredited hospitals	51.80	71.00	62.43	71.54 [71.54]	51.06	53.04	54.34	49.84	47.34	B 41.88 [41.88]	50.41
LABs	37.47	43.02	65.55 [65.55]	40.00	29.87	34.37	29.06	29.94	B 28.70 [28.70]	34.86	29.66
HHAs	29.74	36.79 [36.79]	36.21	B 20.00	29.79	34.02	26.68	31.37	27.87	27.10	30.7

SOURCE: MMACS data current as of 01/07/86

ATTACHMENT 3

▨ Highest Processing Time (Per Facility Type)

☐ Lowest Processing Time (Per Facility Type)

AVERAGE NUMBER OF DAYS
BETWEEN RO RECEIPT AND RO APPROVAL
CY 85

R = Red B = Blue	U.S.	REGION I	REGION II	REGION III	REGION IV	REGION V	REGION VI	REGION VII	REGION VIII	REGION IX	REGION X
18 & 18/19 SNFs	15.85	32.21	20.85	17.40	14.23	10.69	[45.29]	B 5.68 [5.68]	5.65	13.35	16.22
19 Only 1/ SNFs	24.58	47.56	33.54	27.28	13.47	15.13	[79.72]	21.29	B 6.01 [6.01]	7.95	15.70
ICFs 1/	24.75	60.86	91.20 [91.20]	23.31	10.21	15.91	29.37	12.26	B 4.54 [4.54]	22.54	56.37
ICFs/MR 1/	65.15	103.99	143.42 [143.42]	24.73	15.99	26.95	107.36	40.81	B 6.48 [6.48]	12.81	21.20
Accredited Hospitals	13.86	35.95 [35.95]	14.44	30.19	10.11	7.80	32.63	B 2.85 [2.85]	3.91	5.73	7.24
Unaccredited Hospitals	25.66	19.00	44.57	36.92	16.94	15.27	[57.26]	8.81 [8.81]	13.00	20.35	16.94
LALs	14.51	25.32	23.97	19.87	15.88	14.12	[35.14]	3.01	8.19	2.83 [2.83]	8.42
HHAs	18.43	23.95	22.01	21.15	11.76	17.44	31.56 [31.56]	6.09 [6.09]	7.38	20.12	26.39

SOURCE: MMACS data current as of 01/07/86

1/ Average number of days between RO receipt and entry into MMACS.

[3/17/86]

[FM:] Director
Division of Systems
THROUGH: Henry Kretschmaier, Director
Office of Program Support
[RE:] OPS Support of MMACS

[TO:] Philip Nathanson, Director
Health Standards and Quality Bureau

When the HSQB realignment was implemented (as part of "Nibbler Two") approximatedly two years ago, the systems management responsibility for all data processing/management information needs, for the Medicare/Medicaid Automated Certification System (MMACS), were transferred from the Office of Survey and Certification (OSC) to the Office of Program Support (OPS). It became apparent several months after this realignment there was a significant lack of understanding between these affected HSQB components, concerning the new responsiblities of each office to the other. These misunderstandings were highlighted by a lack of communication between OSC and OPS. In an effort to clearly define what everyone's new responsibilities are, as dictated by this realignment, we sent a memo to OSC on August 29, 1984, as a result of a meeting with the HSQB Director on August 7, 1984, outlining the following OPS data processing responsibilities:

1. OPS, Division of Systems, will review and clear all requests for modifications to existing and future systems maintained in the CORDT Network, including MMACS; and

2. All future changes in forms designs and/or the establishment of new provider groups should involve a representative from DS during the development stage to assure that all of HSQBs data/processing needs are provided for.

Although we thought that any misunderstandings would be resolved as a result of our memo, we were wrong. In early 1985, OSC began sending programming specifications directly to BDMS without any review and/or input from OPS. On February 22, 1985, we once again sent a copy of our August 29, 1984, memo to OSC to restate our concerns. However, it now appears that misunderstandings are not a problem, the fact is that OSC is obviously attempting to abrogate our responsibilities to support MMACS. Since February 1985, the following revisions to MMACS have been implemented without involving OPS to the degree needed to keep us informed on system changes:

1. Front-End Data Entry Process
2. Federal Monitoring Surveys
3. Life Safety Code
4. New Outcome-Oriented Survey Process for SNFs and ICFs
5. MMACS Case Control System

Additionally, we (OPS) recently prepared observations/comments in response to a scathing audit report prepared by the OIG on the ineffectiveness of MMACS. These observations/comments were never incorporated with OSC's in the bureau's reply to the OIG. We certainly want OSC to state their opinion, however, we interpreted their response as an apology for MMACS instead of constructive comments concerning the realities of the OIG's report. Whereas, we attacked each point in the OIG report, and in fact, defended MMACS since the report obviously reflected a regional office management problem and not a MMACS problem. After all, should OSC comments be anymore significant than OPS? To further illustrate our concerns, DS has recently been told that a task force was being established to redesign MMACS. However, we have been told that Ray Frederick and I, could not be a part of this task force. Why we are being excluded is not clear to us. We suspect one reason we were excluded was the alledged comments made by the Director of OSC stating that Ray Frederick and I were of "limited vision". If these alledged comments are true they are not only slanderous but detrimental to our character, comptency and reputation. Interestingly our vision was broad enough to take MMACS from an antiquated batch processing system on the UNIVAC to a state-of-the-art IBM online system. It was OPS's 'vision' that provided:

1] On-Lined Hardwired ITT Terminals;

2] Provided Full Screen Data Entry and Front-End Editing;

3] Improved and Updated Software Programs;

4] Improved Response Time to the MMACS Data Base;

5] Developed and Implemented State Agency Direct-Data Entry;

6] Eliminated the 45-Minute Time Limit on RADARS.

Page 3 - Philip Nathanson

As you can see, there are some serious problems that exist between OSC and OPS concerning data processing. It would appear to be an appropriate time for a meeting to establish some clear direction for OPS staff so we will understand our role to this apparent change of bureau policy. If our responsibility to MMACS has been abrogated, I believe a delineation of responsibility is preferable to operating under the veil of suspicion and innuendo.

Donald G. Sikora

HCFA/HSQB/OPS/DDS/RFrederick:cp 3/17/86
0146J
File Code DS100.4D

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

6325 Security Boulevard
Baltimore, MD 21207

MAR 21 1985

Mr. Conrad Thompson, Director
Bureau of Nursing Home Affairs
Mail Stop HB-11
623 8th Avenue SE
Olympia, WA 98504

Dear Mr. Thompson:

The implementation of the new long-term care survey process will be somewhat delayed beyond the originally targetted date of April 1 because it appears that the final rule mandating States to use the prescribed Federal process will not be published prior to that date. We currently expect the final rule to be published in late April or early May.

I would like to emphasize that despite this delay, our current expectation is that we will promptly implement the new long-term care survey process after publication of the final rule. Accordingly, between now and publication of the final rule this spring, you should continue all training activities in your State so that the fullest possible complement of surveyors will be ready and available to implement the new LTC survey process. To assist you in your training efforts and give you a better understanding of the LTC survey process, I am enclosing a copy of the "Report on the New Long Term Care Survey Process." This report describes how the new long-term care process became a reality and what it is intended to accomplish.

Final approved survey forms for use in the new process are currently being printed and will be automatically distributed to each State. These forms should not be used until we or the HCFA regional office notifies you of the new implementation date. I am also enclosing copies of the final draft survey report forms which include the prefix tags used to collect the deficiency information. The training manuals distributed at the nationally-sponsored training programs contained an earlier version of the forms without the prefix tags.

As a follow-up to the six nationally-sponsored training courses on the LTC survey, we will be sending you a training module to assist you with followup training. The module will consist of 1/2" VHS video tapes of an overview of the LTC survey, resident interview skills and Part B survey techniques. A slide-tape tour and exercise, plus an instructor's guide, will complete the module. Additional participant's manuals can be obtained from:

> The National Technical Information Service
> U.S. Department of Commerce
> 5282 Port Royal Road
> Springfield, Virginia 22161

Page 2

If you have any questions on the new long-term care survey process, please contact your HCFA regional office.

Sincerely yours,

Sharon Harris

Sharon Harris
Acting Director
Office of Survey and Certification

Enclosures

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care
Financing Administration

Region X
M/S 409
2901 Third Avenue
Seattle, WA 98121

March 26, 1986

Conrad Thompson, Director
Bureau of Nursing Home Affairs
Department of Social and Health Services
Mail Stop HB-11
623 8th Ave. S.E.
Olympia, Washington 98504

Dear Mr. Thompson:

The implementation of the long-term care survey process (LTCSP) will be somewhat delayed beyond the original targetted date of April 1, 1986. This delay is necessary because of our need to publish a final rule mandating the use of the LTCPS. We expect the final rule to be published in late April or early May. However, it is our intention to implement the LTCSP promptly after publishing the final rule.

We will proceed with the training of all State Agency and the Regional Office staff. The planning for this training was accomplished March 17th and 18th by members of SA and RO staff.

The two day training session for your State is scheduled for April 16th and 17th. The trainers will consist of your staff and RO staff. We have sent the Training Manual to the printers and should be able to mail them to you by March 28th . The audio visuals should be available by the 5th of April.

Survey forms for the LTCSP are being printed and a supply will be sent to you. I want to caution you against using these new forms until you are notified to implement this new survey process.

If you have any questions or need additional information, contact me at (206) 442-8162.

Sincerely,

Ronald L. Hansen
Ronald L. Hansen, Director
Survey and Certification Program
Division of Health Standards and Quality

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date MAR 28 1986

Henry R Desmarais

From Henry R. Desmarais, M.D.
Acting Administrator Ref.: HSQ-096-F

Subject Regulation Action Memorandum - Final Rule - Alternative Sanction for Long-Term Care Facilities.

To The Secretary
Through US__________
ES__________

ACT AS SOON AS POSSIBLE

The alternative sanction will encourage the prompt correction of deficiencies without requiring the drastic measure of terminating the facility's provider agreement and its participation in the Medicare or Medicaid program. This regulation is being closely followed by the Senate Special Committee on Aging, and was the subject of a recent Jack Anderson column in the Washington Post.

Purpose

To implement section 916 of the Omnibus Reconciliation Act of 1980 (Pub. L. 96-499), which provides an alternative sanction (denial of payment for new admissions) which HCFA or the Medicaid agencies may impose, as a general rule, when a SNF or ICF has deficiencies that do not pose immediate jeopardy to patient health and safety.

Background

Before the enactment of section 916 of Pub. L. 96-499, if a State survey agency determined that a SNF or ICF did not comply with one or more of the conditions of participation (for SNFs) or standards (for ICFs), the only sanction available to HCFA or the Medicaid agency was to terminate the facility's provider agreement. The denial of payment sanction established by section 916 is not a substitute for the long-standing authority to terminate the provider agreement. HCFA and the state Medicaid agencies retain the authority to terminate whenever they consider it necessary, even during the 11-month period for which the denial of payment is imposed.

Section 916 also expanded the scope of the Secretary's "look-behind" authority, i.e., the authority to validate State determinations of whether a facility is in compliance with the conditions of participation or standards. Under Federal regulations that pre-date section 916, HCFA, as the Secretary's delegate, could determine that the survey had not been done in accordance with Federal rules and that, therefore, the provider agreement did not constitute evidence of compliance with the conditions or standards. In such cases, HCFA could deny FFP in State payments made to that facility for services furnished to Medicaid recipients. Under the expanded authority provided by section 916, HCFA may now also terminate the facility's participation in the Medicaid program.

Section 916 did not alter existing appeals procedures. Accordingly, SNFs that participate in Medicare continue to have a right to a full evidentiary hearing before an Administrative Law Judge after the effective date of termination. Similarly, under Medicaid, facilities continue to have a right to a full evidentiary hearing either before or, if the State prefers, within 120 days after, the effective date of termination of the provider agreement.

On February 21, 1985, we published a proposed rule (50 FR 7191) to implement section 916. That NPRM elicited 52 letters of comments, which are discussed in detail in the preamble to this final rule.

PROVISIONS

Implementation of the alternative sanction requires both revision of some existing rules and addition of new rules The new rules are §§442.118 and 442.119 for Medicaid, and §§489.60 through 489.64 for Medicare. These new rules --

1. Provide as follows:

   a. The alternative sanction may be applied only when a facility is out of compliance with one or more of the conditions of participation (for SNFs) or standards (for ICFs).

   b. If the facility's deficiencies do not pose immediate jeopardy to patient health and safety, HCFA or the Medicaid agency may either terminate the provider agreement or deny payment for new admissions. (In determining which sanction to impose, HCFA considers factors such as the facility's compliance history and the number and seriousness of the deficiencies.)

   c. If the facility's deficiencies do pose immediate jeopardy to patient health and safety, HCFA or the Medicaid agency must terminate the provider agreement. Moreover, section 916 requires in such cases that HCFA will, and the Medicaid agency may, additionally impose the alternative sanction.

While the statute requires this sequence of events, programmatically it is unworkable. Specifically, HCFA terminates Medicare provider agreements within a few days, with opportunity for hearing after the effective date of termination. The alternative sanction, on the other hand, cannot be imposed until after the facility has been given the opportunity to correct the deficiencies, an informal hearing, and a 15-day notice. Thus, it is clear that denial of payment only for new admissions cannot be imposed "in addition to" termination, which is a much more rapid procedure and cuts off all payments to providers.

d. If HCFA applies the alternative sanction to a SNF that also participates in Medicaid, HCFA will require the Medicaid agency to deny Medicaid payments for the same period for which Medicare payments are denied.

e. It is the Medicare appeals procedures that are available to a sanctioned SNF that participates in both programs. (See §§442.119(c) and 489.60(b)).

2. Require HCFA or the Medicaid agency to fulfill the following requirements before denying payment for new admissions:

   a. Give the facility notice of the deficiencies and an opportunity to correct those deficiencies.

   b. If the facility does not correct the deficiencies during the time specified in the notice of deficiencies, give the facility notice and an opportunity for an informal hearing on the proposed denial of payment for new admissions.

   c. If the informal hearing decision is adverse to the facility, give the facility and the public advance notice at least 15 days before the effective date of denial of payment.

Denial of payment for new admissions does not apply to individuals who were in the facility before the effective date of denial, even if they become eligible for Medicaid after that date. (See §§442.118(b) and 489.62.)

3. Provide, with respect to the alternative sanction --

   a. That it will continue in effect until the end of the eleventh month after the month it becomes effective, unless, before that time, HCFA or the Medicaid agency finds that the facility has corrected the deficiencies or is making a good faith effort to correct them, or that the deficiencies are such that it is necessary to terminate the provider agreement.

b. That HCFA will and the Medicaid agency must -

1) Terminate a facility's provider agreement upon a finding that the facility has been unable to achieve compliance with the conditions (for SNFs) or the standards (for ICFs) during the time the denial of payment was in effect;

2) Make the termination effective the day following the last day of the 11-month denial of payments period; and

3) Follow the usual procedures for appeals from termination, as set forth in Part 405, Subpart O of the Medicare rules, and in Part 431, Subpart D of the Medicaid rules. (See §§442.119 and 489.64.)

The informal hearing on proposed denial of payments would be offered by HCFA for SNFs that participate in Medicare, and by the Medicaid agency for facilities that participate only in Medicaid. It would provide the facility an opportunity to present, in writing or in person, evidence and documentation to show that it is not out of compliance with the conditions or standards for which deficiencies were cited. The facility would receive, from HCFA or the Medicaid agency, a written notice setting forth the reasons for the hearing decision.

If the decision is to impose denial of payment, the facility would receive notice stating the effective date of denial (no earlier than 15 days after the date on the notice), the duration of the sanction, and the reasons for the denial of payment, and the public would be notified at the same time.

Changes in existing regulations were needed --

1. To add definitions of "immediate jeopardy" and "new admission".

Since it is the presence or absence of "immediate jeopardy" that determines whether HCFA or the Medicaid agency has the option of terminating the provider agreement or denying payment for new admissions, a definition was added to §489.3 of the Medicare rules and §442.2 of the Medicaid rules.

In the Medicaid rules we have also defined "new admission" to specify that, if the State plan includes payment for reserved beds, patients readmitted to a reserved bed are exempt from the denial of payment sanction. A reserved bed is a SNF or ICF bed reserved for a Medicaid recipient who leaves the facility temporarily (for instance, for required hospitalization or for a brief home visit included in the plan of treatment) and is expected to return to the reserved bed at the end of the temporary absence.

2. To clarify appeal rights.

   Specific appeals procedures for Medicare providers and suppliers are set forth in Subpart O of Part 405 of the Medicare rules. The termination of a provider agreement for failure to comply with the conditions of participation is an "initial determination" subject to the Subpart O provisions. However, since the alternative sanction does not exclude the facility from participation in the program, the Subpart O appeals procedures do not apply. Accordingly, in §405.1505, which lists administrative actions that are not initial determinations (and therefore are not subject to the Subpart O provisions), we have added a new paragraph (o) to make clear that the following are not initial determinations:

   - A finding that the SNF's deficiencies pose immediate jeopardy to patients' health and safety.
   - The choice of sanction (termination of provider agreement or denial of payments for new admissions) when the SNF's deficiencies do not pose immediate jeopardy.

   These clarifying changes ensure that there will be no confusion regarding the Congress' stated intent not to change the existing appeals procedures.

3. To clarify the Medicaid reserved bed policy by revising §447.40(a) to specify that the Medicaid agency may pay for reserved beds if --

   (1) The State plan provides for such payments and specifies any limitation on the policy; and

   (2) Absences for purposes other than hospitalization are included in the patient's plan of care.

4. To strengthen policy on required termination of provider agreements.

Under previous regulations, termination would have been used in situations that endangered patients' health and safety. Now that there is a specific statutory mandate for terminations in "immediate jeopardy" situations, we have made the rules even more precise by amending §489.53 for Medicare, and adding §442.117 to the Medicaid rules. Section 489.53(b) states that HCFA will terminate a SNF's provider agreement if the SNF's deficiencies pose immediate jeopardy to patients' health and safety. Section 442.117 --

- Requires the State survey agency to terminate a facility's certification of compliance when the facility's failure to meet applicable conditions (for SNFs) or standards (for ICFs) poses immediate jeopardy; and
- Cites the applicable termination procedures that the Medicaid agency must follow.

5. To shorten the advance notice period from 15 days to 2 days when the facility's deficiencies pose immediate jeopardy to patients' health and safety.

6. To reflect changes in delegations of authority to terminate provider agreements.

   Final regulations published by the Department on September 13, 1985 (50 FR 37370) reflect several changes in delegations of authority. One of those changes means that, in certain circumstances, the Department's Office of the Inspector General (OIG), rather than HCFA, is responsible for termination and notice of termination of a provider agreement, and for reinstatement after termination. To make clear when the authority rests with HCFA, and when with the OIG, we revised §§489.53 and 489.57 and added a new §489.54.

COSTS/SAVINGS

We anticipate that most facilities will correct the deficiencies before the correction period expires, so that the alternative sanction will be applied in few cases. The costs of administrative hearings and resurveys will be incurred regardless of which sanction is imposed. Accordingly, we expect no major increases in costs or savings as a result of publishing this final regulation. Neither a Regulatory Impact Analysis under Executive Order 12291 nor a regulatory flexibility analysis under the Regulatory Flexibility Act has been prepared for this final regulation.

ISSUES

1. Whether to reduce, from 15 days to 2 days, the advance notice period in "immediate jeopardy' situations.

   In the preamble to the proposed rule we requested comment on this issue. Eleven of the twelve comments on this question favored the 2-day notice. We believe that quick action is necessary to protect beneficiaries in immediate jeopardy situations, and that 15 days is simply too long a waiting period. A two-day notice is consistent with the procedures we follow in terminating Medicaid facilities found, upon "look-behind" review, to be out of compliance with the conditions of participation.

2. Whether to broaden the definition of "immediate jeopardy". Although we did not change the definition itself, we did provide examples that do broaden the concept as it was perceived by some who commented on the proposed rule.

3. Whether to establish specific time frames for each step in the process of imposing the alternative sanction.

   In the final rules, we have established a period of up to 60 days as a "reasonable" time for correction of deficiencies when the deficiencies do not pose immediate jeopardy to patients' health and safety.

4. Whether to adhere strictly to the language of the law, which requires that termination (because the facility has not achieved compliance during the alternative sanction period) be effective on the first day of the first month after the last month the denial of payment was in effect. We do not believe that Congress intended to permit deficient facilities to continue to participate in the program beyond the eleven-month period, as would be the case if for example, the 11-month period ended on the 5the day of a month and termination could not be effective until the first of the following month. Accordingly, we decided to use our longstanding statutory authority to terminate a deficient facility at any time, as a basis for making termination effective on the day after the last day of the denial of payment period. We

believe that programmatically we can accomplish this by providing a facility that is failing to correct noted deficiencies with a 15-day termination notice that would coincide with the day following the expiration of the 11-month correction period.

Attachment A Final Rule.

PREPARED BY:HCFA/BERC/RS LIglesias 1/17/86 245-0383 (#7133D)
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HSQ-096-F

CONGRESSIONAL INTEREST

Following publication of the proposed rules in February 1985, the Senate Special Committee on Aging, chaired by Senator John Heinz, raised numerous concerns about the substance of these regulations, particularly with respect to the possible use of the alternative sanction as a substitute for termination in "immediate jeopardy" situations. The Committee also questioned whether the Department was sufficiently responsive to public comments it had received on the proposed rules. During several meetings in late summer of 1985, Committee and HCFA staff thoroughly explored the Committee's concerns. Although final rules incorporate many Committee suggestions, the Committee can be expected to continue to criticize these regulations, and seek prompt publication of promised clarifying guidelines.

Although there has been no other Congressional correspondence nor any other inquiries concerning these alternative sanction regulations during the past two years, Senator Weiker has a continuing interest in LTC survey and certification, QC, and "look-behind issues." In addition, there has been significant Congressional interest in the concept of broadening the use of alternative sanctions beyond current law and regulations.

Appendix C

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

2086

Memorandum

Date APR 3 1986

Henry R Desmarais

From Henry R. Desmarais, M.D.
Acting Administrator
Health Care Financing Administration

Subject OIG Draft Report — Use of the Medicare and Medicaid Automated Certification System (ACN 03-60154)

To The Inspector General
Office of the Secretary

We have reviewed the draft audit report and agree with the OIG that Medicare and Medicaid Automated Certification System (MMACS) information should be kept current and accurate. The report contains a number of useful findings and we intend to use the report as part of our effort to improve MMACS. We will also make the OIG report available to our regional office financial staffs for their information and use.

Our comments on the specific sections and recommendations of the report are attached for your consideration.

Attachment

Comments of the Health Care Financing Administration on the OIG Draft Audit Report - Use of the Medicaire/Medicaid Automated Certification System (MMACS)

Following are our comments regarding the specific sections of the report.

MMACS - Designed to be an Effective Management Tool

We do not know where the OIG obtained the $2 million figure cited in this section. According to the Departmental evaluation of the system in 1985, the total annual operating cost of the MMACS Network is less than $900,000.

MMACS is not an Effective Management Tool for Monitoring Long-Term Care Facilities

We do not agree with the conclusion that MMACS is not being used as an effective management tool for monitoring State survey and certification activities. We are continually striving to improve the accuracy and timeliness of the data. Following are some of the steps we have taken toward that end:

o State Agency (SA) Direct Data Entry

As the OIG findings indicate, delays can occur from the time the survey takes place to when the results are forwarded to the regional offices (ROs) for review and data entry. To eliminate unnecessary paperflow and facilitate timely data entry, we began a pilot project in 1984 in four States to test the feasibility of transferring the responsibility for data entry from the regions to the States. The results have been effective judging by Washington State's average processing time of 62 days from survey to system processing for long-term care providers. This compares to 107 days as cited in the OIG-report. The pilot will be extended to 12 States in 1986.

o Front End Data Entry

In March 1985, we made an important change in how certification kits were processed in the regions. We now require the regions to enter all recertifications into MMACS upon receipt in the ROs prior to review by the certification specialists. (We refer to this process as "front-end data entry".) Computer-based flags screen the recertification cases and identify facilities requiring professional review. These flags consist of certain critical requirements including conditions of participation which, if not met, will identify problematic facilities. The "flagged" facilities are then reviewed by the professional staff. Unflagged cases require no professional review after entry into MMACS. Because the cases are being entered into MMACS as soon as they are received in the ROs, the lag time in entering certifications into MMACS has been significantly reduced.

o Case Control System

In conjunction with the "front-end data entry process", we developed a standardized MMACS-based case control system in September 1985. These tables provide central and regional office management with important information for monitoring certification activity and identifying processing bottlenecks. In addition to providing summary data on the number of recertification cases that are received, cleared, pending in the regions, and pending over 30 days in the regions, the case control reports also identify cases that are due from the States. This last report enables the regions to identify any recertification cases that have not been forwarded by the States within the prescribed timeframes.

- o Survey and Certification Operations Report (SCOR)

  In July, 1985 we issued the first in a continuing series of quarterly reports to the Regional Administrators and top level HCFA management on certification activities in the ROs. The SCOR focuses on various aspects of certification activity each quarter using MMACS as its primary data source. Through the SCOR we have been alerting the ROs to excessive processing times, processing bottlenecks, and improper processing and/or certification procedures. When significant problems are uncovered through analysis of SCOR (i.e. MMACS data), followup memoranda are sent to the ROs outlining the problem and recommending specific actions to be taken.

- o Adverse Action Extract, HCFA-462

  Recently, we developed a new form (HCFA-462) to ensure the prompt processing of certification actions where there is the potential for adverse action (terminations and denials of payments for new admissions (alternative sanctions)). The pertinent information from the form will be entered into MMACS, and based on our analyses of the data, if the SAs or ROs fail to process these actions in accordance with manualized processing time limits, their failure will be documented and brought to their attention during the State and RO evaluation programs.

- o Future MMACS Enchancements

  Over the next few years, we plan to expand and upgrade the MMACS to be a more effective and efficient state-of-the-art management information system. Our plans include modifying the data base to capture more patient-specific information and less statistical and deficiency-related information. We will focus our attention on outcomes of patient care rather than on facility compliance with the traditional structure and process.

  Another way we plan to enhance the data system is to streamline the data collection and entry techniques. As mentioned previously, within two years we expect all the States to be entering the survey results directly into the data base instead of forwarding the hard copies to the ROs for review and data entry. Our ultimate goal is to have a "paperless process" in which surveyors will use hand-held computers to collect information about a facility, its patients and its compliance and then transmit the data telephonically to the States and regions.

We would like to emphasize that MMACS is being continuously used by HCFA to evaluate RO performance. In fact, MMACS data along with other information available in HCFA will be used this year to evaluate the majority of ROs. Additionally, we are developing a computerized State Agency Evaluation Program, to evaluate each SA's performance under the revised Section 1864 Agreement. This process, when implemented, will rely heavily on MMACS data.

In addition, although this section of the report indicates that results of facility surveys are not entered into MMACS timely, this is contrary to what we observed during our evaluation of all the ROs (Division of Health Standards and Quality) in mid-1985. In the course of these reviews, we did find that in two ROs there was a relatively small backlog. However, in both cases the ROs were taking steps to eliminate their backlogs.

Moreover, we found that the ROs use MMACS data, not only in evaluating SA processing times, but in the review of a facility's past compliance history. Although some RO staff have been slow to accept MMACS, we believe that the system is being used to monitor the SAs and providers.

MMACS Shows Thousands of Long-Term Care Facilities As Not Being Surveyed Within 15 Months

We agree that long-term care facilities must be surveyed annually and we rigorously enforce this requirement. There is a strong possibility that OIG staff misinterpreted some MMACS data. To illustrate, consider the following example. The facility was surveyed in September 1984 and issued an agreement which began on January 1, 1985 and expired on December 31, 1985. The SA resurveyed the facility in November 1985 and forwarded its certification to the RO within the required 45 days. The RO received the certification on December 21, 1985, but because of the holiday, the kit is not entered until January 4, 1986. Review of MMACS 15 months after the September 1984 survey would not have revealed a survey as having been completed. In this case, the survey could have been even later, had the SA requested a two month extension from the RO.

In addition, some further distinction must be made between Medicare certifications and Medicaid-only certifications. Medicaid certifications are not approved by the RO. Therefore, the certification data is not entered until the information is received from the Medicaid SA, which may be 120 to 150 days after the date of survey. There is no requirement that SAs must forward Medicaid certifications to the ROs within 45 days, since RO approval of the certification is not required.

In addition, the data on work processing times from the statistical sample of 230 surveys cited in this section was interesting because it differs significantly from a similar analysis we have done on the same subject. The statistical sample in the OIG report reflected an average processing time of 107 days from survey date to entry into MMACS. Results of our analysis (see Attachments 1 - 3 from SCOR report dated February 1986) indicate the average processing times of all Medicare and Medicare/Medicaid skilled nursing facilities is significantly lower than the sample findings:

Overall average processing time - 71.89 days

Average number of days between survey date and SA review signoff - 45.97 days

Average number of days between RO receipt and RO approval - 15.85 days
(Note - Since 10/85, the majority of recertifications (i.e. unflagged cases) are entered into MMACS on the same day the RO approves them).

Our analysis indicates that the OIG conclusion is grossly in error and the SAs are operating within the timeframes set forth in the State Operations Manual.

HCFA Recognizes Need to Monitor Survey Activities but Review Methods Need Improvement

We disagree with the OIG's contention that the ROs have selected inappropriate States for review in some cases, and that our mandate that one State per region be reviewed is inadequate. We have historically deferred to the ROs in the selection of particular States for review, subject to our concurrence, in part so that the ROs can rotate their reviews through all States to ensure that each State is eventually reviewed in all key areas. Moreover, we will generally not conduct a review in a given State if the OIG has just performed a review on the same subject in that State (e.g., Illinois and Indiana with respect to certification reviews).

The targeting of States for reviews must also reflect consideration of staff availability, travel funding, and competing review priorities. For example, even if reliable MMACS data indicate that all States in Region V require provider agreement reviews, we cannot focus all Region V financial staff on that area at the expense of other critical responsibilities. Nor can we shift staff from one region to another to perform reviews. Our review strategy emphasizes areas which are of major national significance, have experienced recent regulatory or policy changes, or are high-risk areas which have not recently been reviewed. It must also be pointed out that these reviews are in addition to monitoring done on all States by the Division of Health Standards and Quality in the ROs.

With regard specifically to the certification reviews, the OIG report argues that disallowances should start with fiscal year (FY) 1985, rather than FY 1986 as stated in the financial review guide we disseminated last fall. The OIG position is based on the fact that the Director, Health Standards and Quality Bureau (HSQB) wrote the ROs in January 1983, that States should start phasing back into an annual survey schedule, and that he issued another memorandum in August 1984 stating that States should by then be back on that schedule.

In fact, the original (June 1982) policy issuance authorizing less-than-annual facility surveys under certain circumstances was not explicitly rescinded until June 5, 1985, when the HSQB Director so notified all ROs and they in turn advised all States through the FY 1986 survey and certification budget guidelines. The June 1985 memorandum stated that every Medicaid facility must have been surveyed in FY 1985 if its provider agreement was to be considered valid after September 30, 1985. Our financial review guide states the same policy. Our onsite reviews of the ROs last year confirmed that the ROs are requiring annual surveys.

Attachment

ATTACHMENT 1

■ Highest Processing Time (Per Facility Type)

□ Lowest Processing Time (Per Facility Type)

AVERAGE NUMBER OF DAYS
BETWEEN SURVEY DATE AND RO APPROVAL
CY 85

R = Red B = Blue	U.S.	REGION I	REGION II	REGION III	REGION IV	REGION V	REGION VI	REGION VII	REGION VIII	REGION IX	REGION X
18 & 18/19 SNFs	71.89	91.39	89.53	69.30	63.48	78.00	■	62.01	B 57.53	57.59	63.14
19 Only 1/ SNFs	63.51	70.18	■	54.35	65.55	62.48	59.29	75.01	55.04	59.43	B 36.79
ICFs 1/	65.73	55.74	■	60.47	59.15	85.32	48.32	52.75	B 45.78	57.41	67.95
ICFs/MR 1/	78.55	76.00	■	68.81	67.98	65.96	78.81	74.93	80.06	B 62.93	67.45
Accredited Hospitals	51.96	60.66	48.55	62.76	41.92	56.50	■	B 34.22	45.42	43.24	38.09
Unaccredited Hospitals	86.36	96.88	■	115.81	74.86	83.27	119.25	B 64.51	65.25	84.54	80.37
LABs	61.11	80.15	■	66.14	53.11	56.08	71.73	B 38.39	41.80	47.31	44.52
HHAs	56.14	67.81	■	47.20	47.65	60.22	65.61	43.71	B 39.98	60.11	64.19

SOURCE: MMACS data current as of 01/07/86
1/ Average Number of Days between Survey Date and Single State Agency Sign Off

ATTACHMENT 2

■ highest Processing Time (Per Facility Type)

☐ Lowest Processing Time (Per Facility Type)

AVERAGE NUMBER OF DAYS
BETWEEN SURVEY DATE AND SA REVIEW SIGNOFF
CY 85

R = Red B = Blue	U.S.	REGION I	REGION II	REGION III	REGION IV	REGION V	REGION VI	REGION VII	REGION VIII	REGION IX	REGI
18 & 18/19 SNFs	45.97	50.04	52.81	43.24	42.57	■	50.39	49.05	42.93	B 31.73	25.
19 Only SNFs	45.02	58.54	■	38.84	45.98	49.65	48.69	54.13	49.60	34.05	B 30.1
ICFs	46.85	45.44	58.42	45.19	46.95	■	34.60	43.21	40.81	B 30.83	50.
ICFs/MR	54.77	46.83	66.10	47.45	50.10	53.07	55.18	67.16	■	B 29.34	61.
Accredited hospitals	30.09	35.08	25.58	B 22.01	25.34	37.80	■	24.85	37.17	25.84	[illegible]
Unaccredited hospitals	51.80	71.00	62.43	■	51.06	53.04	54.34	49.84	47.34	B 41.88	50.
LABs	37.47	43.02	■	40.00	29.87	34.37	29.06	29.94	B 28.70	34.86	29.
HHAs	29.74	■	36.21	B 20.00	25.79	34.02	26.68	31.37	27.67	27.10	30.

SOURCE: MMACS data current as of 01/07/86

ATTACHMENT 5

■ Highest Processing Time (Per Facility Type)

☐ Lowest Processing Time (Per Facility Type)

AVERAGE NUMBER OF DAYS BETWEEN RO RECEIPT AND RO APPROVAL CY 85

R = Red B = Blue	U.S.	REGION I	REGION II	REGION III	REGION IV	REGION V	REGION VI	REGION VII	REGION VIII	REGION IX	REGION X
18 & 18/19 SNFs	15.85	32.21	20.85	17.40	14.23	10.69	■	B 5.68	5.65	13.35	16.22
19 Only 1/ SNFs	24.58	47.56	33.54	27.28	13.47	15.13	■	21.29	B 6.01	7.95	15.70
ICFs 1/	24.75	60.86	■	23.31	10.21	15.91	25.37	12.26	B 4.54	22.54	56.37
ICFs/MR 1/	65.15	103.95	■	24.73	15.99	26.95	107.36	40.81	B 6.48	12.81	21.20
Accredited Hospitals	13.86	■	14.44	30.19	10.11	7.80	32.63	B 2.85	3.51	5.73	7.24
Unaccredited Hospitals	25.66	19.00	44.57	36.92	16.94	15.27	■	8.81	13.00	20.35	16.94
Labs	14.51	25.32	23.97	19.87	15.88	14.12	■	3.01	8.19	2.83	8.42
HHAs	18.43	23.95	22.01	21.15	11.76	17.44	■	6.09	7.38	20.12	26.39

SOURCE: HMACS data current as of 01/07/86

1/ Average number of days between RO receipt and entry into HMACS.

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

6325 Security Boulevard
Baltimore, MD 21207

APR 3 1986

Dear

In the course of conducting our Termination Workshops for State and HCFA regional office personnel, several questions were raised by the course participants. To ensure consistent and uniform understanding and application of the revised procedures, we told each group that we would compile the questions asked, respond to each in writing, and distribute our written responses to the regional offices and State agencies.

These questions and answers (Qs&As) will be distributed as part of a training package which will be sent to our regional offices to enable further training of regional and State agency staff. We are also providing copies of this memorandum to our Associate Regional Administrators so they can share this information with States in their regions.

Because of your involvement and helpfulness in developing the termination procedures, I wanted you to be among the first to see the Qs&As. The responses are consistent with those given over the past several months to other organizations, such as the General Accounting Office and the Office of the Inspector General, that have requested clarifications of the revised procedures.

I trust you will find the Qs&As helpful and informative.

Sincerely yours,

Sharon Harris

Sharon Harris, Acting Director
Office of Survey and Certification, HSQB

Enclosure

cc:
ARAs, DHSQ Region I-X
Bob Dublin, OGC

Identical letters were sent to the following Termination Workgroup Members:

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Questions and Answers
Termination Procedures

The following questions were raised in the course of the recently conducted Termination Workshops. Responses are being circulated to ensure uniform understanding and implementation of the revised procedures.

Q1. Do the revised procedures apply to facilities having time-limited agreements? Would not non-renewal be more appropriate than termination?

A1. Whether to terminate or non-renew will depend on when the survey is conducted and whether or not there exists an immediate and serious threat to patient health and safety. Generally speaking, non-renewal would be the action of choice if there is not a threat and the survey is conducted 90 days before the agreement's expiration date. Termination would be used when there is an immediate and serious threat, or when the survey is conducted more than 90 days before the expiration date of the agreement.

Q2. What would you do if you found an immediate and serious threat in a SNF/ICF? Would you terminate both?

A2. Action should be initiated against both agreements if the problem cannot be isolated to the SNF or ICF.

Q3. Is the provision that Medicare payments, for patients admitted before termination, will continue for up to 30 days following the effective date of termination still in effect?

A3. Yes.

Q4. When do the new procedures go into effect?

A4. The procedures were effective December, 1985. However, the States and HCFA regional offices will be given a reasonable amount of time to implement the new procedures. The procedures must be implemented by March 1, 1986.

Q5. How can the termination process be stopped?

A5. Only the actual achievement of compliance stops termination action. Promises to correct or progress towards correction is not by itself a legitimate basis for delaying action.

Q6. By what date does the provider have to submit a plan of correction (PoC)?

A6. The provider is not required to submit a PoC. Only compliance will stop termination action. A PoC, however, if submitted, should be reviewed and evaluated to ascertain whether or not compliance is likely to be achieved. Thus, if a provider expects to achieve compliance within a reasonable amount of time, it would be prudent for the facility to apprise the State agency (SA) and HCFA of that intent.

Q7. What happens if the provider does not submit a PoC?

A7. As mentioned above, a PoC is not necessary. If the provider achieves compliance and it is substantiated by the SA or RO, termination action will be stopped.

Q8. What happens if the deficiencies that you cited are corrected, but then you find, upon resurvey, that there are new deficiencies that pose an immediate and serious threat to patient health and saftey?

A8. First, complete a new HCFA-462. Then, initiate the 23 day procedure.

Q9. If the date of survey falls on a Friday or the day before a holiday, when is day 1?

A9. In the 23 day procedure, day 1 is the first working day following the survey. This means that weekends and holidays are not counted. In the 90 day process, day 1 is the day after the conclusion of the survey.

Q10. Do you use the HCFA-2567 for notification of deficiencies in the 23 day process?

A10. In the 23 day process, the notice on Day 2 will be in narrative form and should minimally focus on those deficiencies that pose the immediate and serious threat. The HCFA-2567 could be used, however, if time permits its completion. If the narrative is used, a HCFA-2567 containing all deficiencies must be sent to the facility and the regional office (RO) by the 10th day. This would provide a complete notice of deficiencies, which would be essential if the provider is successful in eliminating the immediate and serious threat. The HCFA-2567 will always be used to notify the facility in the 90 day procedure.

* Q11. Can Exhibit No. 4-40 be used for any facility?

A11. Exhibit No. 4-40 is the model termination notice for laboratories. However, you may use selected paragraphs from any of the model notices if they are appropriate.

Q12. What is considered supporting documentation?

A12. Supporting documentation, as required in section 3010 B.3., means: HCFA-2567s, correspondence with the provider, reports of provider contacts, HCFA-1539, complaint investigations, etc. In other words, it includes any information, which the RO may not have, that supports the termination action.

* Exhibit No. 4-40 is located in the Regional Office Manual, Transmittal No. 23 (December 1985), Chapter 6.

Q13. In section 3010 B., what is the difference in the materials sent to the RO on the 3rd and 10th day? In other words, if the facility is notified of its deficiencies on the 3rd day, why would notice again be sent again on the 10th day?

A13. If, by the 3rd day the HCFA-2567 has been prepared, there is no need to prepare another notice of the 10th day. The intent was to give the SAs more time to prepare the often lengthy HCFA-2567s, while ensuring that facility will receive prompt notice of deficiencies that pose an immediate and serious threat to patient health and safety.

Q14. Who sends the HCFA-2567 to the facility?

A14. The SA should send the HCFA-2567 to the provider and the RO. If the facility submits a PoC, the SA should forward a copy of the facility's PoC to the RO.

Q15. Is the 23rd day deadline an absolute time frame?

A15. Twenty three days is the outside time limit and we expect the SAs and ROs to work together to meet this time limit.

Q16. Can a surveyor send the facility a HCFA-2567?

A16. If the SA allows the surveyor to prepare and send the HCFA-2567, the surveyor may do so. However, because the HCFA-2567 constitutes the official SA findings, the HCFA-2567 is usually reviewed at higher levels in the SA before being forwarded to the provider.

Q17. If a surveyor finds an immediate and serious threat on the first day of survey, should the survey be continued?

A17. If such a threat is found, the provider should be immediately notified as well as the SA. Although the survey would not have to be completed, other deficiencies that are likely to be found would be useful in documenting the extent of the facility's non-compliance. This would help to ensure that the action would be sustained by an administrative law judge (ALJ) or other reviewing authority. Continuing the survey would enable monitoring of the facility's efforts to eliminate the threat, and further, it would negate the need for a second visit where the provider eliminates the immediate and serious threat.

Q18. What is the role of the Ombudsman in the procedures?

A18. The Ombudsman should be notified that termination action is being taken. The Ombudsman can be useful in facilitating the relocation of patients and residents to facilities and for ensuring the health, safety, and overall well-being during such transfers.

Q19. What is the role of the SA in these procedures?

A19. For Medicare, the SA is essentially a finder-of-fact. The SA's functions include: conducting onsite surveys, citing deficiencies, relating those deficiencies to regulatory requirements, and then, to certifying those findings to the RO. The SA would also conduct resurveys, as required.

Q20. What is the role of the RO?

A20. For Medicare, the RO is the determining authority. The RO reviews the survey findings and determines, based on the documented findings, whether or not termination action should be initiated.

Q21. What happens if an 18/19 facility, during termination, withdraws from Medicare?

A21. Because the RO has the look behind responsibility, the RO would proceed against the Medicaid agreement unless the SA continues the action on its own. If the SA pursues the action, the RO should assist the SA by furnishing any supporting documentation it has to the SA.

Q22. How do you determine reasonable progress?

A22. Reasonable progress is the actual correction of a significant number of deficiencies. However, it is not relevant following a finding of non-compliance. Progress may not be used either as a substitute for compliance, or as a basis for postponing termination action.

Q23. Does a facility have to be in full compliance before termination action can be stopped?

A23. A facility must meet all of the applicable conditions. If the conditions are met, but not all of their subordinate requirements, i.e., standards, factors, or elements, the agreement may be continued if other deficiencies are covered by an acceptable plan of correction.

Q24. What is the HCFA-462? Does it replace the C & T?

A24. The HCFA-462 was developed to monitor SA and RO adherence to termination processing timeframes. The form is used whenever a facility is cited as not meeting one or more conditions. For ICFs, the form should be completed when the deficiencies cited will result in a certification of non-compliance unless actually corrected before certification.

Q25. Is the HCFA-462 sent to the RO?

A25. THe HCFA-462 will typically be initiated by the SA and copies forwarded to the RO immediately following specific SA actions; i.e., survey, follow-up visit, certification of compliance, etc.

Q26. Is the Medicaid State agency required to fill out the HCFA-462?

A26. The Medicaid State agencies are being asked to complete appropriate sections of the HCFA-462. If the forms are not completed by the Medicaid agency, the ROs will be asked to complete the forms to enable monitoring of the State's processing of both Medicare and Medicaid termination actions.

Q27. How is "new" look behind different from "old" look behind?

A27. Old look behind is essentially a review of the State's interpretation, application, and enforcement of State Plan Requirements. If the State does not adhere to State Plan Requirements in its survey and certification activities, HCFA will disallow Federal matching funds for facility-specific claims filed by the State. New look behind focuses not on the State's adherence to requirements, but rather on the actual compliance of Medicaid-only facilities. If HCFA finds that such a facility does not meet Medicaid requirements, HCFA must cancel that facility's certification.

Q28. What constitutes an immediate and serious threat?

A28. Determining what situation or situations constitute an immediate and serious threat is a matter of professional judgement. Generally speaking, they would be conditions so serious that correction by the facility must be immediate, in other words, patients are in immediate jeopardy. For Medicare, these findings will be reviewed by Federal surveyors, which will ensure more uniform decisions.

Q29. When will HCFA accept a voluntary termination?

A29. HCFA may refuse immediate withdrawal, and will do so, if such a withdrawal would result in a loss of coverage for Medicare beneficiaries. If the withdrawal is requested after the RO's decision to terminate, the provider would have to meet the reasonable assurance test before being readmitted to the Medicare program.

Q30. What happens if a facility has repeated deficiencies?

A30. An agreement with a long-term care facility may not be renewed if the facility is cited as having the same standard level deficiency in a successive certification survey and the provider did not achieve compliance during the prior period of certification. If the facility achieved compliance, the deficiency must have recurred despite the good faith efforts of the facility to maintain compliance, and the reasons for the deficiency must have been beyond the control of the facility.

Q31. Who will notify providers of the new procedures?

A31. Long-term care and hospital associations were involved in the development of the procedures. Other Associations will learn of the procedures because they subscribe to the HCFA Manuals and will receive the transmittals. Other groups will learn of the procedural revisions through SA and RO implementation.

Q32. If the State chooses to take action under its licensure process instead of the certification process, is there a conflict?

A32. Yes. Licensure procedures may not be used as a substitute for the revised procedures. However, there is no conflict if the two processes are implemented concurrently.

Q33. What is the automatic cancellation clause?

A33. The automatic cancellation clause is a provision that requires that a conditional time-limited agreement be cancelled if standard level deficiencies are not corrected by the dates in the approved plan of correction. The clause may be rescinded if the provider can show good faith efforts and progress.

Q34. How will the alternative sanction interact with the new procedures?

A34. The denial of payment for new admissions is an alternative to termination, and as such will not alter the termination procedures. They will, however, be cross-referenced in the program manuals. Criteria will be provided to ensure that the alternative sanction is used appropriately.

Q35. If a Federal district court intervenes to stop the termination, should the court's decision be appealed?

A35. The writ of injunction should be appealed to the Circuit Court of Appeals. The due process requirements afforded providers have been tested and sustained in the courts. District courts should respect the administrative process by allowing it to run its course, before intervening.

Q36. How many standards have to be out for a condition to be out?

A36. There is no specific number of standards that must be cited deficient before a condition will be cited as not met. The surveyor must use his or her professional judgement and interpretive guidelines to determine whether or not the deficiencies cause the intent of the condition not to be met.

Q37. What is an acceptable plan of correction?

A37. An acceptable plan of correction is a plan of action that will result in compliance within a period of time acceptable to the authority that determines compliance with program requirements. Moreover, it is a plan that will enable participation while corrective action is being taken. If a condition is not met, there cannot be an acceptable plan.

Q38. Can a surveyor's personal notes be used to support termination action? If so, when?

A38. Personal surveyor notes are particularly useful when trying to recall exactly what was observed during an onsite survey. Personal notes may be subpoenaed, however, so writing comments that would be embarrassing or would undermine a future adverse action should be avoided. Restricting notes to first-person observations will enhance their value.

Q39. If a surveyor finds a serious deficiency, should another surveyor be asked to witness the situation?

A39. Corraboration is always a good idea, not because it is needed to convince the provider, but rather because it will increase the probative value of testimony.

Q40. What is a surveyor's obligation to a facility regarding consultation?

A40. A surveyor is called upon to inspect a facility for compliance, which is a enforcement function and thus opposite to that of furnishing consultation, or assistance. The primary responsibility for achieving and maintaining compliance rests with the providers. The provider is capable of identifying the least costly and most effective way of eliminating the deficiencies. It is encumbent on the surveyor to explain carefully the deficiency and how each deficiency relates to a particular regulatory requirement.

Q41. Are surveyors required to give an exit conference?

A41. Surveyors may refuse to conduct an exit for almost any reason, however, States are encouraged to discuss their findings with the provider, particularly when an immediate and serious threat was found. Surveyors should refrain from arguing with the provider. The provider has every right to disagree with the findings. If the exit is taped, we recommend that the survey team refuse to conduct an exit, unless they are given a copy of the tape at the conclusion of the exit. If the provider is represented by counsel at the exit (and all participants at the exit should identify themselves) you may refuse to conduct an exit conference.

Q42. How many revisits must be made?

A42. Revisits must be made when there is a credible allegation of compliance. Criteria for determining what consititues a credible allegation are included in section 3014.

Q43. How many years of documentation are needed to terminate a Medicare or Medicaid provider?

A43. Failure to meet any one of the conditions, or failure to submit an acceptable plan of correction for standards or other requirements is a cause for termination. There does not have to be a history of non-compliance.

Q44. What kinds of documentation are needed to satisfy the requirements imposed by 42 CFR 442.105.

A44. Documentation must provide a justification, not a conclusion. For example, 42 CFR 442.105(a) requires written justification that the deficiencies do not jeopardize patient health and safety. The documentation should explain in descriptive phrases the analysis of the SA that led to the conclusion that patient health and safety are not jeopardized by the deficiencies cited.

Q45. Can the SA extend the agreement of a Medicaid-only facility with the prior written approval of the Medicaid State agency?

A45. No. Written approval must be obtained before the current agreement expires.

Q46. Does HCFA have the authority to review Medicaid non-longterm care facilities?

A46. Yes. Section 1902(a)(33)(B) of the Social Security Act provides the authority.

Q47. If the HCFA RO refuses the SA's certifictaion decision, can the SA appeal to a higher level?

A47. The ROs and SAs should work together to resolve such disagreements. However, the RO has the final word, based on its delegated authority.

Q48. What does termination accomplish? The reasons for termination are usually removed by the time the hearing is conducted.

A48. Compliance with program requirements must be maintained. If a facility is found not to meet participation requirements, participation is ended and payment ceases. Termination is the lawful consequence. It is not intended to serve any particular social or program need.

Q49. Does the reasonable assurance provision apply to Medicaid facilities?

A49. If HCFA terminates a Medicaid facility under its look-behind authority, reasonable assurance applies and the RO will made that determination. If a Medicare/Medicaid SNF is terminated by HCFA and that facility reapplies for participation only in the Medicaid program, the reasonable assurance provision applies and that determination is made by the Medicaid State agency. There is no reasonable assurance provision for ICFs, ICFs/MR, or Medicaid-only SNFs terminated by the State.

Q50. How does PaCS relate to the termination procedures?

A50. PaCS is a survey method. As such, a determination of non-compliance resulting from a PaCS survey would be processed using the revised procedures.

Q51. Suppose the SA initiates the 90 day process, which means that the RO will not see the survey documentation until 55 days after the survey, and the RO determines that there existed an immediate and serious threat?

A51. The RO, assuming the conditions still exists, would accelerate the process to terminate as soon as possible. The RO should then work with the SA to resolve the difference in professional judgement to avoid similar problems in the future.

Q52. Can termination action be taken if only one meaningless Condition is not met?

A52. None of the conditions are meaningless. Failure to meet any one of the conditions is cause for initiating termination action.

Q53. What is day zero; i.e., what is the date of survey?

A53. The date of survey is the date on which the onsite survey is completed.

Q54. Do these procedures apply to accredited hospitals?

A54. Yes, when there is an immediate and serious threat to patient health and safety. We are initiating action to revise the manuals and the regulations to conform the procedures for all providers and suppliers.

Q55. Suppose a facility eliminates the immediate and serious threat, but does not achieve compliance by the 23rd day?

A55. The facility would be given up to an additional 67 days to achieve compliance. In other words, the 90 day process would be applied.

Q56. Suppose a provider disagrees with the survey findings? Cannot those findings be appealed?

A56. Survey findings, per se, may not be appealed. An adverse determination that results from those findings, however, may be appealed.

Q57. What is a current survey?

A57. A survey is considered current if it was conducted within the last 120 days.

Q58. Can receiverships be used to delay termination?

A58. No. Receivership is a provision under many State licensure laws. As such, the provision may be used in addition to, but not instead of Federal requirements.

Q59. What is the effect of these procedures for Medicare and Medicaid?

A59. For Medicare, these procedures are requirements that must be followed. For Medicaid, since the procedures are not State Plan Requirements, the States cannot be required to follow them. However, the States should appreciate that these procedures define, from HCFA's standpoint, what consitiutes good practice. Therefore, SAs that follow these procedures do not have to be concerned about potential disallowances. The further a State strays from these procedres, the greater the risk that HCFA may disallow Federal matching funds for a particular facility.

Q60. What provisions has HCFA made for relocating patients following termination?

* A60. Section 4220 is dedicated to the relocation of patients. It clarifies that States may claim Federal financial participation if it makes special efforts to ensure the safe and orderly transfer of patients.

* Section 4220 of the Regional Office Manual, Transmittal No. 23, (December 1985)

Q61. The regulations require that providers be given a reasonable opportunity to correct deficiencies. How do these procedures conform to that requirement?

A61. Twenty three days is more than a reasonable opportunity when there exists an immediate and serious threat to patient health and safety. If the threat is removed the facility may be given more time to achieve compliance. Likewise, 90 days is more than enough time to allow non-compliance with major participation requirements.

Q62. We understand that where a facility eliminates the immediate and serious threat we can switch from the 23 to the 90 day process. But, suppose the notice of termination has alaready been published. Do we publish a retraction? Would a new notice have to be published if we have to terminate by the 90th day?

A62. If termination will not be effective on the day in the published notice, another notice should be prepared. This notice should indicate that:

1. termination action is being postponed because the facility has taken action to remove the threat to patient health and safety; and

2. termination will be effective on (the 90th day after survey) if compliance with program requirements has not been achieved.

Thus, a separate notice would not be required at a later date.

Q63. We keep getting contradictory interpretations of the repeat deficiency provisions in 42 CFR 442.105 (d) and the 405.1908 (b) and (e). What is the correct interpretation?

A63. We have discussed these provisions at length and we continue to believe, as we did in 1979 (in our proposed rule), that the provisions are overly mechanistic and contrary to ensuring the availability of long-term care services to program beneficiaries. At the same time, we do believe that the provisions can be quite useful in ending the participation of facilities that have clearly demonstrated their inability or unwillingness to maintain compliance with program requirements.

The issue is, what is expected of the States.

After further deliberation, we expect the following interpretation to be followed.

1. The repeat deficiency provisions are applicable when the same standard or standards are cited as deficient in consecutive certification surveys.

2. When the provision applies and the State does not invoke the provision, the State must be able to provide documentation that the requirement, triggering the provision, was met some time during the current certification period.

3. The State must be able to furnish documentation, if requested, that the deficiency recurred despite the best efforts of the facility, and

4. that the provider could not have prevented the deficiency(ies).

In other words, the provisions should be used whenever the same deficiency persists throughout the current period of certification. However, if compliance was achieved, but not maintained, a decision regarding the facility's intent and effort to maintain compliance must be made. In this regard, we expect reasonableness. This means the nature of the deficiency, its effect on patients, whether the deficiency has persisted, and the overall efforts of the provider must be given full consideration. In other words, be reasonable in determining good faith efforts.

Q64. Suppose, upon survey, the State agency determines that a repeat deficiency exists; that is, it does not meet the exception criteria in the regulations, and there is an immediate and serious threat serious to patient health and safety. Suppose further that the provider removes the threat and corrects the deficiencies. What procedures apply?

A64. The regulations preclude renewal of the agreement if a standard level deficiency existed at the time the current agreement hecame effective and the deficiency persisted throughout the term of the agreement. If the deficiency was corrected but for reasons beyond the provider's control and despite the facility's best efforts, that deficiency is found again to exist, the deficiency is not considered to be a repeat deficiency. Therefore, in the scenario above, the 23 day process would be initiated. However, if the deficiency is corrected and the threat removed and there is no other cause of termination, the termination action would be stopped and the agreement would be renewed.

If the threat is removed but the corrections are not made by the end of the current agreement, the 23 day processed would be stopped and a non-renewal action would be initiated.

In addition to the above questions, the following clarifications were discussed. These clarifications will be included in subsequent revisions to the manuals.

1. Section 3005 D.--If a ICF does not meet standards, its participation may be terminated. Failure to meet any standard is a cause for adverse action if the provider does not submit a plan of correction acceptable to HCFA.

2. Section 3005 G.--The revised procedures and outside processing time limit applies to JCAH validation surveys when an immediate and serious threat is found to exist. The procedures in 42 CFR 405.1901(e) do not apply to immediate and serious threat cases.

3. Section 3010 B.2.b.--This section will be revised to clarify that if the SA uses the HCFA-2567 to notify the facility of its deficiencies, the procedure scheduled for the 10th working day is met.

4. Section 3012(1).--The date of survey is the date on which the survey is completed, which may or may not be the date of the exit conference. The parenthetical phrase should be deleted.

5. Section 3012(3).--The provision will be revised to clarify that resurveys will be conducted only when an achievable plan of correction was submitted, or following a credible allegation of compliance.

6. Section 3016 B.--This provision requires that the SA forward any reports of consultation it may have. The provision will be revised to clarify that special consultation visits are not only not required, but in fact, are discouraged.

National Citizens' Coalition for
NURSING HOME REFORM

Elma Holder, Executive Director
Frieda Garrecht, President

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202-797-0657

April 9, 1986

STATEMENT OF CONCERNS

RE: HCFA'S NEW LONG TERM CARE SURVEY PROCESS (PaCS)

TO: Sharon Harris, Acting Director
Office of Survey and Certification
Health Standards and Quality Bureau, HCFA

We are writing to express concerns about the implementation of the new Long Term Care Survey Process. We commend HCFA for initiating this important change in the way nursing homes are surveyed. HCFA's new long term care survey process is a positive and significant development in nursing home regulation. If implemented properly, it can tremendously strengthen HCFA's ability to monitor and assess the quality of care nursing home residents receive.

We support the process because it provides the opportunity to hear directly from residents about the quality of care and life in the homes. It focuses on the care residents actually receive rather than a home's compliance, in theory, with standards of good practice.

We recognize your agency's unprecedented efforts to share information about this new process and to solicit and incorporate recommendations for improvements. This openness has created an atmosphere for sincere discussion about how to develop a system that will best serve nursing home residents. We commend your proposed work plan which indicates continued agency activities which will contribute to an improved survey process. It is in the spirit of cooperation that we offer concerns and recommendations related to successful implementation of the new long term care survey process.

To be implemented and utilized successfully, this landmark change in nursing home regulation will require tremendous support and cooperation from federal and state regulatory agencies, nursing home providers and residents, and their representatives.

We recognize that it took a great deal of time and thought to develop this new system. Now the Health Care Financing Administration is endangering this new system with a poorly developed, unrealistic and potentially harmful implementation plan including:

(1) an unrealistic implementation schedule. States need more than two or three months to make the transition to the new procedures, format and skills required by the new system. HCFA is to be commended for postponing start-up until 30 days after publication of a Notice of Final Rule which it expects to publish by the end of April. A June start-up is much more reasonable than the planned April 1 date. However, HCFA is requiring that states totally assimilate the new process within two months of start-up.

NCCNHR is a national, non-profit membership organization, founded in 1975, to improve the long-term care system and the quality of life for nursing home residents.

(2) an inadequate approach to training. HCFA is training less than 10% of those who will conduct the new survey and relying on those representatives to return to their states and convey new federal policies and procedures to their co-workers. States will have to purchase training materials and duplicate training manuals in order to provide the basic orientation to their surveyors. The training itself lacks sufficient development in the area of communicating with confused (or those who appear confused) residents and with residents who manifest communication difficulties, yet such communication is essential if the new process is to work.

(3) incomplete guidelines and instructions to surveyors. Current surveyor guidelines, in draft form, are confusing and incomplete, and particularly weak in the areas of residents' rights, residents' social, emotional, and mental health needs and other quality of life areas. HCFA has acknowledged these problems and is revising the guidelines. Although surveyors must begin conducting these new surveys in June, revised guidelines for the survey process will not be completed until October 1.

(4) inadequate recognition of and cooperation with positive innovations and activities of state regulatory agencies. Many states already conduct resident focused, outcome oriented surveys and have a broader range of enforcement tools available to apply to poor homes. HCFA has told state agencies to follow the federal format and procedures without exception, or lose federal financial participation, and has expressed an unwillingness to coordinate with effective state enforcement practices.

We, the undersigned organizations, call upon the Health Care Financing Administration to give the leadership and support necessary to help this system work for the protection and welfare of nursing home residents, by taking action to:

(1) establish a reasonable phase-in period for implementation of this new process, beginning June 1 and continuing through December 31, 1986;

(2) provide direct federal training to every surveyor, to assure consistent direction and clear statements of federal policy;

(3) develop a plan for follow-up training beginning in January, 1987, and to supply training materials for every surveyor and each state agency, particularly in the areas of communication skills, residents' rights, residents' social, emotional and mental health needs, and determining what is a deficiency;

(4) maintain its commitment to revise surveyor guidelines based on the experiences and concerns of surveyors, providers, health care professionals, and consumers after all have had experience with this new process;

(5) allow waivers to states whose innovative survey methods and enforcement practices exceed federal requirements, and to develop a process for approving waivers and reviewing them on a time-limited basis, with participation from regulators, providers, and consumers;

(6) work in partnership with regulators, providers and consumers to educate the public and maximize public participation in and understanding of the process;

(7) establish a task force of regulators, providers, health professionals, and consumers to monitor implementation and evolution of this new system and assist in development of training materials, surveyor guidelines and public education activities.

This new process is an evolutionary one. If implemented correctly, it can contribute to the many reforms in the system that are necessary - reforms that are addressed in the March, 1986 Institute of Medicine report.

Changes in the way surveyors conduct surveys will require changes in approach, in attitudes, in skills, and in experience. These changes are much too important to be lost by shortcuts during this critical implementation period.

Co-signers of the Statement of Concerns

American Association of Homes for the Aging
American Association of Retired Persons
American Federation of State, County and Municipal Employees
American Foundation for the Blind
American Health Care Association
American Nurses Association
American Occupational Therapy Association
American Psychological Association
American Society of Consultant Pharmacists
National Association of Area Agencies on Aging
National Association of Social Workers
National Association of State Long Term Care Ombudsman Programs
National Association of State Units on Aging
National Citizens' Coalition for Nursing Home Reform
National Committee to Preserve Social Security and Medicare
National Consumers League
National Council of Senior Citizens
National Support Center for Families of the Aging
Service Employees International Union
Unitarian Universalist Association

Call John [illegible]

Association of Health Facility Licensure and Certification Directors

AHFLCD

April 21, 1986

The Honorable David Durenberger
United States Senator
SR-154 Russell Senate Office Bldg.
Washington, D.C. 20510

Dear Senator Durenberger:

I am writing on behalf of the Association of Health Facility licensure and Certification Directors to inform you of our support of the Institute of Medicine (IOM) report released by the National Academy of Sciences. The report, pertaining to nursing homes, is the first comprehensive review of federal nursing home requirements in over a decade. It provides a needed framework for improving the quality of life and care for nursing home residents. In our view, it is vitally important that a systematic approach be adopted to implement any changes. Strategic planning will maximize both program and cost effectiveness.

The Health Care Financing Administration is the entity responsible for planning, developing and coordinating implementation of Medicaid program changes. It is essental that consumers, providers and state regulators be involved in these efforts, as they are the change agents who must finally implement changes. Such comprehensive efforts will ensure nursing home residents are the ultimate benefactors.

The Association will be forwarding to you a specific response regarding the recommendations of the IOM report. We pledge our full support and cooperation. We would appreciate being notified of scheduled hearings and we are available to testify.

We are very concerned about the present proposal to reduce federal matching funds for Medicaid certification surveys, in addition to further budget cuts resulting from Gramm-Rudman. To reduce survey budgets now, when the federal government is mandating a new national survey process which requires additional resources, poses the gravest consequences for the nation's ability to monitor health care. We note that less than one percent of the Medicaid budget goes to survey.

monitoring the health care of a nation

If you desire further information or we may be of assistance, please write or call me at (304) 348-0050.

Sincerely,

/s/
John J. Jarrell
President

cc: AHFLCD Board Members
George Degnon
Elma Holder
Patricia Nemore
Dr. Thomas Vernon

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date APR 21 1986

From Director
Health Standards and Quality Bureau

Subject Survey and Certification Operations Report--Second Quarter FY 86

To Regional Administrators
Regions I - X

Topics this quarter include the following:

(Chart #) Work Processing Times

1 o Overall Work Processing Time - CY 84/85
Average Number of Days from -
2 o RO Receipt to RO Approval
3 o RO Approval to MMACS Masterfile
4 o Survey Date to RO Approval
5 o Survey Date to MMACS Masterfile
6 o Work Processing Times - 18 and 18/19 SNFs (Recerts Only)

Other Topics

7 o Facilities with COPs Out of Compliance as of 04/86
8 o FY 86 Budget Approvals - Medicare
9 o FMS Surveys Performed - FY 85
10 o PPS Excluded Hospitals and Units

The focus of this quarter's report is work processing time and how it has been affected by front-end data entry which has been in effect for about a year. The first six charts in this report relate to work processing timeframes.

HIGHLIGHTS

Work Processing Time (Charts #1 - #6)

Front-end data entry went into effect, nationwide, on March 11, 1985. Using "front-end", certification kits are entered into the system upon receipt in the RO, prior to any substantive review by certification specialists. The system is programmed with indicators (i.e., a COP or critical requirement out of compliance at the time of survey) which will flag a case, containing one of those indicators, for review.

Some of the reasons for going to this system of data entry are to eliminate in-depth RO review of facilities with good compliance records; to eliminate the bottleneck of cases awaiting review prior to data entry; and to reduce the workload of the certification specialists in the RO giving them more time to devote to the review of problem providers.

Ultimately, it was expected that this change in procedure would result in an overall reduction in work processing time.

Overall Work Processing Time - CY84/CY85

Chart #1 is a bar graph comparing overall work processing time for CY 84 and CY 85 at four key workstops:

a) RO receipt to RO approval
b) RO approval to the MMACS masterfile
c) Survey date to RO approval
d) Survey date to the MMACS masterfile

Review of the chart indicates the following:

- In 1985, processing time from RO receipt to RO approval was reduced 6 days over CY 84,
- Processing time from RO approval to MMACS masterfile was reduced 19 days,
- Processing time from Survey date to RO approval was reduced 7 days
- Overall processing time in 1985 from Survey date to MMACS masterfile was reduced 28 days over 1984.

Charts #2, 3, 4 and 5 break down Chart #1, by region and by facility type, for each of the four workstops giving more specific data on the reduction in processing time. Analysis of the charts indicates the following:

- There are large fluctuations in processing time between facility types and between regions.
- National processing time from Survey date to MMACS masterfile ranges from a low of 88 days for Labs to a high of 278 days for CORFs in CY 84.
- In 1985, the above figures change to a low of 72 for accredited Hospitals and HHAs, and a high of 138 for Hospices - a significant reduction over 84.

As expected, the biggest reduction in work processing time, between CY 84 and CY 85, occurs at the workstop from RO Approval to MMACS Masterfile:

- In 1985, the number of processing days saved at this workstop, over '84, ranges from 9 days (Hospices) to 138 (CORF).

  Actual Processing time (U.S.) at this workstop ranges as follows:

	84	85
Low (in days)	24 (Labs)	15 (RHC)
High (in days)	169 (CORF)	70 (Hospice)

Processing time fluctuates significantly among the ROs for different facility types and even within the same type. Following are some examples:

- As reflected in MMACS, overall processing times in '84 (i.e. survey date to MMACS Master file) range from a low of 56 days (HHAs) in one region to a high of 881 days (ESRD) in another.

- In '85, the times range from 45 days (HMA) to 343 (Acc. Hosps.)
- For one facility type, 18 and 18/19 SNFs, the regional processing times range from 87 to 218 days in '84 and from 66 to 182 in '85.

Because the data for Charts #1 through #5 were drawn from MMACS Table 12 which includes processing times for initials as well as recertifications and for flagged as well as unflagged certifications in '85, it is difficult to draw specific conclusions regarding the wide range in the processing times between regions and facility types.

Work Processing Time - 18 & 18/19 SNFs (Recerts Only)

Chart #6 displays a further breakdown in processing times and focuses on the processing times for flagged versus unflagged certifications for one facility type. Because a recent OIG report (02/86) on MMACS focused primarily on processing times for long term care facilities, we chose 18, 18/19 SNFs as the subject for this chart.

Chart #6 contains two bar graphs comparing work processing times for flagged and unflagged cases for the same workstops highlighted in Charts #1-5. The first graph charts the time period between the implementation of front-end data entry nationwide (03/10/85) to the first major change in the front end procedure (10/15/85). During this time period, flagged cases were sent to a certification specialist for review prior to RO approval, and for unflagged cases, the RO approval date was manually entered into the system by RO data entry staff. From 10/15/85 to the present (see the second graph of Chart #6) the RO approval date is computer generated for unflagged cases, which eliminates the extra step of manually entering approval dates for all unflagged cases. As expected, there is a noticeable decrease in RO processing time for unflagged cases after 10/15/85:

- From 03/10 to 10/15/85 the processing time for unflagged cases from RO receipt to RO approval was 12.67 days. From 10/15 to the present, the time dropped to 4.72.
- Processing time from RO approval to reflection in MMACS went from 7.48 days to 3.01 days after 10/15.
- There was also an unexpected reduction in RO processing times for flagged cases.

Looking at the data for 18 and 18/19 SNFs from Charts #2-6, the processing times consistently decreased as follows:

	CY 84	CY 85	3/10-10/15/85 (flagged/unflagged)	10/15/85-Present(03/86) (flagged/unflagged)
RO receipt to RO approval	23	16	16.81/12.67	12.27/4.72
RO approval to MMACS Master file	41	16	11.28/7.48	6.87/3.01
Survey to RO approval	82	72	74.54/61.7	78.46/61.4
Survey to MMACS Master file	122	88	85.82/69.19	85.28/64.41

Facilities with COPs out of Compliance (Chart #7)

On February 13, a memorandum from the OSC Director was sent to the ARAs regarding the significant number of facilities with COPs out of compliance that was reflected in MMACS. The ROs were asked to review the files for these facilities to verify the accuracy of the data. We received replies from six regions. Virtually all of those regions explained that most, if not all, of the COPs that are reflected as deficient in MMACS are in fact in compliance but are shown as deficient for three basic reasons:

1) COPs were cited as deficient (particularly in HHAs and Hospitals) when there was no other place to cite a factor or standard level deficiency other than at the Condition level.

2) Revisits and revisit reports (HCFA-2567Bs) were done indicating a deficiency had been corrected but those reports were not entered into MMACS.

3) Keying errors. Condition data tags were erroneously entered into MMACS as deficient.

Chart #7 is an update of the chart that accompanied the February memorandum. It shows a sizable decrease (as of 04/04/86) in the number of facilities with COPs out of compliance, however, there is still a significant number being reflected in MMACS. Because MMACS is being used increasingly for purposes of analysis, monitoring and management reporting, all regional offices should take action to remove COP deficiencies from MMACS if in fact they are not deficient.

Medicare State Certification - FY 86 Budget Approvals (Chart #8)

Chart #8 reflects FY 86 Medicare State certification costs per FTE and associated hourly rates. The data was generated from regionally approved State budgets from HCFA Forms 1467 and 2815. Hourly rates assume States receive at least 1600 hours of effort from each staffer.

Following are the State certification cost categories along with the lowest and highest State figures:

	Average Salary Cost	Fringe Benefit Rate	Fringe Benefit Cost	Travel	Other Direct Costs	Indirect Cost Rate	Indirect Cost	Cost Per FTE	FY 86 Hourly Rate
Low	$10000	0%	$0	$443	$460	0%	$0	$15869	$9.92
High	$38221	40.5%	$10929	$8013	$39233	53.5%	$18027	$70840	$44.28

This data will be used in the unit cost budget methodology that is currently under development in central office. The new methodology will utilize each State's current mandatory requirements for salaries, fringe benefits, indirect costs, etc.

Regional budget negotiators should review Chart #8 and use it when negotiating States' FY 1987 budgets. Effort should be made to ensure parity among the States.

FMS Surveys Performed in FY 1985 (Chart #9)

- The number of FMS surveys targeted for performance in FY 85 varied among regions and ranged from a low of 53 to a high of 96 per region.

- In all regions, the number of surveys actually performed, as reported by the regions, was more than the targeted amounts and ranged from a low of 70 to a high of 203.

- The surveys performed per FTE ranged from 11.6 in one region to 25.4 in another. The national average was 16.3.

During the last round of ROPES reviews, it was noted that the number and types of surveys being performed and counted as Federal surveys varied significantly among regions. The wide variation in the numbers of surveys actually performed, per FTE, in each region (see Chart #9) seems to bear out the ROPES findings.

The MMACS FMS Subsystem became operational in 12/85 and the ROs are entering survey data back to 10/85. Having FMS data in MMACS eliminates the need for manual reporting by the regions. Because the types of Federal surveys are broken down into 9 categories in MMACS, the number and type of surveys being performed, for each facility type in each region, will be readily available.

PPS Excluded Hospitals and Units (Chart #10)

Following are the total number of PPS excluded hospitals and units as of 12/31/85:

Hospitals

Psychiatric - 491
Rehabilitation - 72
Alcohol/Drug - 27
Long Term - 92
Childrens - 56

Units

Psychiatric - 831
Rehabilitation - 423
Alcohol/Drug - 344

Chart #10 shows the number of PPS excluded hospitals and units reported by the regions as of 12/31/85 and the number reported in MMACS as of 03/18/86. The figures indicate that MMACS is basically up to date in reflecting PPS exclusions. There have been some problems with entering the data on PPS exclusions into the system timely. In the next report, the chart will reflect the number of PPS exclusions as reported by the regions and the number reflected in MMACS for the same time period.

Philip Nathanson

Attachment

cc: Associate Regional Administrators, DHS&Q
Acting Associate Administrator for Operations

Chart #1

OVERALL WORK PROCESSING TIME

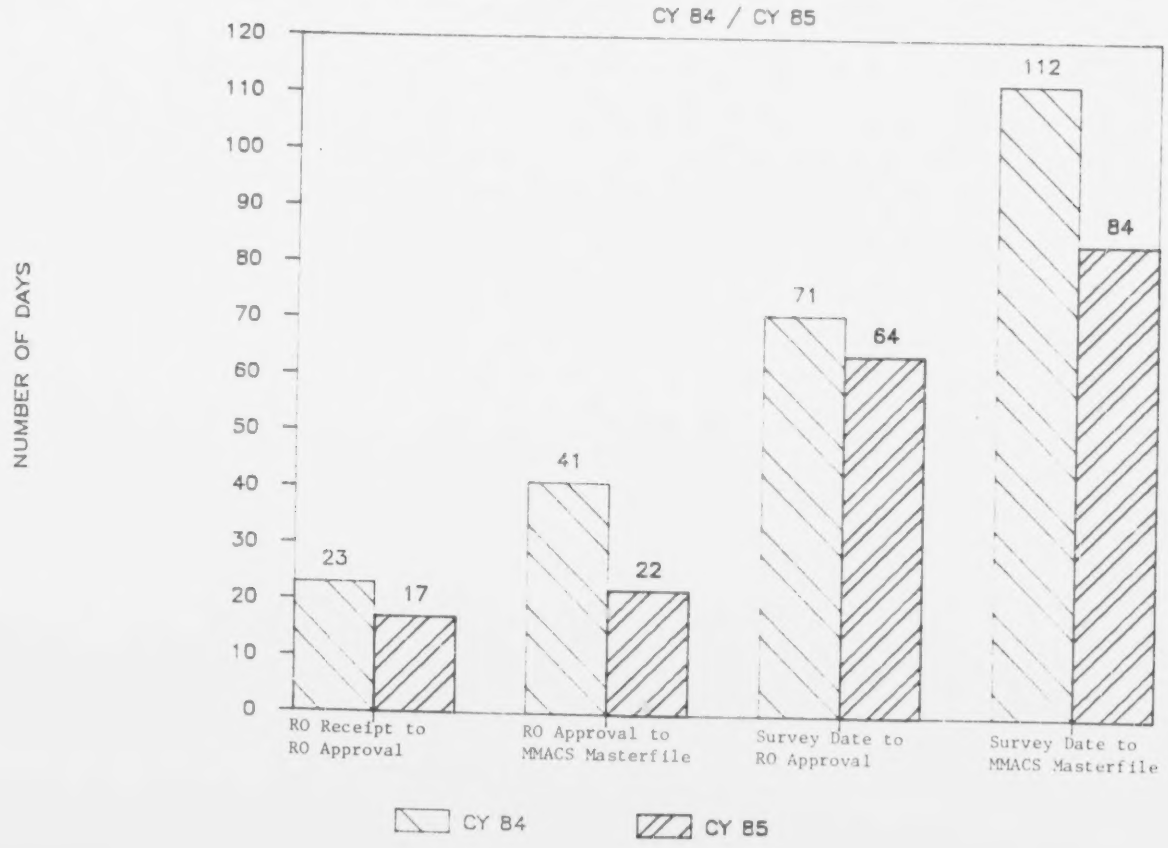


Chart #2

AVERAGE NUMBER OF DAYS
FROM RO RECEIPT TO RO APPROVAL
CY 84/CY 85

PROVIDER TYPE	U.S.	REGION I	REGION II	REGION III	REGION IV	REGION V 1/	REGION VI	REGION VII	REGION VIII	REGION IX	REGION X
	84/85	84/85	84/85	84/85	84/85	84/85	84/85	84/85	84/85	84/85	84/85
18 & 18/19 SNFs	23/16	19/32	22/20	9/17	22/14	41/11	50/45	13/6	12/10	18/13	30/16
Unaccredited Hospitals	31/26	47/19	30/45	23/37	25/17	39/15	67/57	12/9	19/13	24/20	26/17
Accredited Hospitals	16/14	37/36	15/14	10/30	19/10	19/8	33/33	10/3	8/4	6/6	12/7
HHA	30/18	26/24	28/22	21/21	19/12	42/17	54/32	11/6	11/7	30/20	26/26
Lab	16/15	20/25	16/24	12/20	14/16	35/14	45/35	11/3	11/8	3/3	11/8
ESRD	27/26	70/35	33/26	12/19	20/15	58/47	63/41	14/15	20/21	20/20	36/20
OPT	29/20	29/96	17/25	22/25	18/12	67/22	54/29	12/4	11/15	31/21	25/18
X-Ray	19/17	10/85	32/15	7/14	16/11	54/35	72/19	10/5	13/9	5/6	2/7
ASC	24/22	19/15	54/11	20/14	16/11	61/32	54/50	11/6	23/10	16/22	15/11
RHC	18/14	14/15	22/30	7/18	15/11	41/16	5/12	16/5	7/12	15/15	23/11
CORF	56/28	51/87	/4	42/41	38/22	138/20	68/17	6/7	4/2	51/23	27/8
Hospice	35/23	/51	/21	35/41	34/14	26/17	/38	/8	11/18	36/30	59/27

Source: MMACS Table 12 for CY 84 and CY 85

1/ The data for Region V is inaccurate due to improper data entry procedures. The figures should be higher.

Chart #3

AVERAGE NUMBER OF DAYS
FROM RO APPROVAL TO MMACS MASTER FILE
CY 84/CY 85

PROVIDER TYPE	U.S.	REGION I	REGION II	REGION III	REGION IV	REGION 1/ V	REGION VI	REGION VII	REGION VIII	REGION IX	REGION X
	84/85	84/85	84/85	84/85	84/85	84/85	84/85	84/85	84/85	84/85	84/85
18 & 18/19 SNFs	41/16	117/55	17/8	41/17	33/5	21/13	80/7	31/21	14/8	41/12	93/16
Unaccredited Hospitals	72/26	168/97	35/57	37/34	55/23	84/30	102/80	48/16	31/7	76/33	158/31
Accredited Hospitals	40/30	84/263	21/14	18/14	36/7	28/23	121/98	34/16	135/6	56/26	73/15
HHA	34/16	73/23	14/10	24/25	36/6	28/8	42/32	25/16	13/5	34/15	72/20
Lab	24/13	74/42	10/11	23/16	20/8	28/8	40/34	24/10	11/10	11/4	53/9
ESRD	94/58	757/200	23/14	30/41	45/27	113/38	152/150	20/45	21/14	118/67	259/71
OPT	32/19	142/83	15/13	28/19	24/6	46/14	31/52	28/18	74/9	42/26	62/21
X-Ray	52/21	621/144	6/3	28/10	24/5	105/45	24/34	35/19	17/1	57/9	16/4
ASC	87/44	447/65	82/7	41/52	41/12	67/18	344/162	37/36	16/18	42/21	210/71
RHC	34/15	92/62	13/12	26/11	28/7	51/11	43/15	17/9	11/6	29/11	83/32
CORF	169/21	316/112	/45	155/19	96/23	271/31	206/29	255/251	108/8	111/9	100/2
Hospice	81/70	/65	/124	143/39	87/27	152/48	/278	/36	155/20	123/111	92/42

Source: MMACS Table 12 for CY 84 and CY 85

1/ The data for Region V is inaccurate due to improper data entry procedures. The figures should be higher.

Chart #4

AVERAGE NUMBER OF DAYS
FROM SURVEY DATE TO RO APPROVAL
CY 84/CY 85

PROVIDER TYPE	U.S.	REGION I	REGION II	REGION III	REGION IV	REGION 1/ V	REGION VI	REGION II	REGION VIII	REGION IX	REGION X
	84/85	84/85	84/85	84/85	84/85	84/85	84/85	84/85	84/85	84/85	84/85
18 & 18/19 SNFs	82/72	101/91	98/90	60/69	72/63	108/78	109/106	81/62	73/58	58/58	78/63
Unaccredited Hospitals	96/86	145/97	132/120	109/116	81/23	108/83	132/119	92/65	82/65	92/85	71/80
Accredited Hospitals	50/52	79/81	52/49	39/63	48/42	54/51	79/89	35/34	49/45	41/43	67/38
HHA	71/56	105/68	85/78	59/47	51/48	88/60	90/66	60/44	43/40	69/60	67/64
Lab	64/61	81/80	95/103	57/66	53/53	81/56	80/72	55/38	50/42	49/47	45/45
ESRD	76/72	124/114	111/110	70/57	55/52	107/89	103/82	43/35	72/78	68/68	141/82
OPT	72/64	130/158	93/89	66/48	54/49	116/92	89/68	54/46	98/132	58/57	71/82
X-Ray	64/60	87/140	82/49	58/49	45/44	108/79	96/58	39/45	62/45	56/57	45/84
ASC	73/69	98/93	128/77	75/63	61/51	156/99	88/100	52/41	80/53	59/63	64/64
RHC	59/56	88/55	95/162	41/55	51/42	83/63	73/49	95/45	49/57	67/63	67/52
CORF	109/68	99/141	/25	62/62	82/61	191/71	110/54	192/40	42/52	141/64	128/44
Hospice	104/69	/87	/70	104/62	70/59	70/72	/74	/38	71/97	96/71	92/71

Source: MMACS Table 12 for CY 84 and CY 85

1/ The data for Region V is inaccurate due to improper data entry procedures. The figures should be higher.

Chart 65

AVERAGE NUMBER OF DAYS
FROM SURVEY DATE TO MMACS MASTERFILE
CY 84/CY 85

PROVIDER TYPE	U.S.	REGION I	REGION II	REGION III	REGION IV	REGION 1/ V	REGION VI	REGION VII	REGION VIII	REGION IX	REGION X
	84/85	84/85	84/85	84/85	84/85	84/85	84/85	84/85	84/85	84/85	84/85
18 & 18/19 SNFs	122/88	218/145	117/97	101/87	105/68	139/91	188/182	111/82	67/66	59/65	172/79
Unaccredited Hospitals	167/122	313/194	168/144	132/150	135/58	152/113	233/200	139/80	113/72	166/118	229/112
Accredited Hospitals	90/72	163/243	73/62	57/77	83/49	82/74	199/187	69/51	164/51	97/70	139/53
HHA	104/72	178/101	99/87	84/72	87/54	115/68	132/98	85/80	56/45	104/75	104/84
Lab	88/74	155/123	105/114	60/62	73/61	109/64	120/165	79/49	61/52	59/51	99/54
ESRD	170/131	881/314	134/124	100/95	166/80	220/127	255/232	64/84	92/94	188/136	379/152
OPT	104/83	271/241	108/107	94/67	78/54	161/105	120/120	82/63	172/140	100/83	133/103
X-Ray	117/81	707/285	88/53	87/56	70/54	213/123	120/92	75/65	79/46	113/66	61/88
ASC	160/113	545/158	210/84	115/115	101/62	223/115	432/262	89/77	96/71	101/84	273/136
RHC	92/71	181/116	108/173	67/66	78/45	135/74	116/64	113/54	59/64	97/74	156/84
CORF	278/99	415/253	/70	217/162	179/84	462/103	316/82	44/65	150/66	252/73	228/46
Hospice	247/138	/152	/194	247/100	157/87	222/120	/352	/74	227/105	219/182	183/113

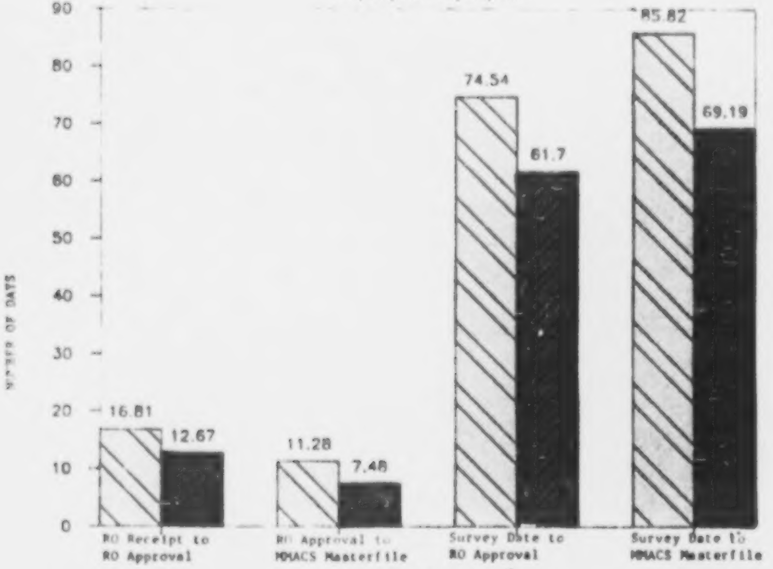
Source: MMACS Table 12 for CY 84 and CY 85

1/ The data for Region V is inaccurate due to improper data entry procedures. The figures should be higher.

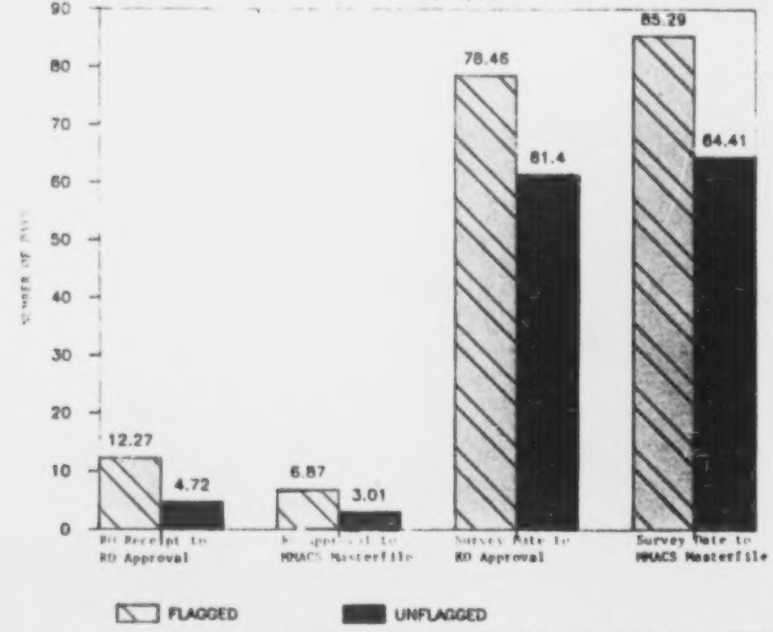
Chart #6

WORK PROCESSING TIMES
18, 18/19 SNFs (Recerts Only)

03/10/85-10/15/85 1]



AFTER 10/15/85 2]



1] Front-end data entry was implemented nationwide on 03/10/85. From 03/10 through 10/15/85 the regions entered "the RO Approval Date", manually, for both flagged and unflagged cases.
2] Effective 10/15/85, "the RO Approval Date" for unflagged cases is computer generated.

SOURCE: MMACS as of 03/18/86

Chart #7

Facilities with Conditions of Participation
Out of Compliance
(as of 04/04/86)

Provider Type	Reg. I #Fac/#COPs	Reg. II Fac/COPs	Reg. III Fac/COPs	Reg. IV Fac/COPs	Reg. V Fac/COPs	Reg. VI Fac/COPs	Reg. VII Fac/COPs	Reg. VIII Fac/COPs	Reg. IX Fac/COPs	Reg. X Fac/COPs	Total Fac/COP
SNFs	5/9	9/15	4/5	2/2	44/62	15/21	1/1	2/2	0/0	2/2	84/119
Unaccred. Hosp.	4/4	1/2	2/4	2/4	14/18	39/94	0/0	1/1	0/0	3/3	66/130
HHAs	8/11	29/44	5/7	1/2	97/164	21/40	0/0	3/5	1/1	5/6	170/280
LABs	9/9	1/2	1/1	1/1	13/13	9/12	0/0	0/0	1/1	1/1	36/40
OPTs	4/4	2/2	0/0	0/0	7/26	5/6	0/0	1/1	0/0	3/5	22/46
ESRDs	12/15	2/2	0/0	0/0	6/6	5/5	0/0	1/1	0/0	1/1	27/30
RHCs	0/0	1/1	1/1	0/0	0/0	0/0	0/0	1/1	0/0	1/1	4/4
ASCs	1/2	0/0	0/0	0/0	2/4	4/5	1/1	4/7	1/1	3/4	17/24
Hospices	0/0	0/0	0/0	0/0	4/12	4/5	1/1	0/0	0/0	2/2	11/20
CORFs	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0

Source: RADARS data current as of 04/04/86

DEPARTMENT OF HEALTH & HUMAN SERVICES
REGION III
3535 MARKET STREET
PHILADELPHIA, PENNSYLVANIA 19101

TELEPHONE
AREA CODE 215
596-6744-6745

OIG AUDIT AGENCY

MAILING ADDRESS
P.O. BOX 13716
PHILADELPHIA,
PENNSYLVANIA 19101

[May, 1986]

Mr. James Michie
United States Senate
Special Committee on Aging
SD-G33
Washington, D. C. 20510

Dear Mr. Jim:

Per your request we have made a computer evaluation of variables contained in the MMACS database. Enclosed for your information are the results which we have not yet fully evaluated. Our application was an attempt to mirror HCFA's criteria used in their 1982 study, and determine if the variables which existed in the data in 1982 still existed in 1986. Although we did not have a complete set of HCFA's results, we were able to use the available statistical data for comparison.

Should you have any questions, do not hesitate to contact me.

Sincerely

Pat Marion

The patterns of variability uncovered during our analysis are similar to patterns found during HCFA 1982 review. Our computer applications showed that variables exist between regions; between states within regions; and, between types of facilities within a state. These patterns exist in both total deficiencies and critical deficiencies reported.

Variability in Total Deficiencies

The percentage of facilities in a region having 20 or more deficiencies ranged from only 20.6% in Region VI to 61.2% in Region IX. Region IX was the only region to have over 50% of its facilities in this category, while three regions had less than 25% of their facilities meet this criteria. The 1982 HCFA study identified three regions over the 50% mark and three regions under the 25% level.(Schedule 1)

This variability pattern also existed between states. We identified 10 states that reported 20 or more deficiencies in over 50% of their facilities and 12 states where this occurred less than 15%. The HCFA study also noted the variables between states, however it only identified four states in each category. (Schedule 2)

The percentage of facilities without deficiencies also demonstrated significant variations. Our analysis identified fifteen states as not having any facilities without deficiencies, while four states (New York, Kentucky, Minnesota and Texas) had over 15% of their facilities without deficiencies.

The 1982 study identified variations between states in the same region, this pattern continued in 1986. In Region II, New York had 26% of its facilities without deficiencies and only 14.8% of its facilities with over 20 deficiencies. Conversely, New Jersey had only 1.6% of its facilities without deficiencies while 71.1% of its facilities had over 20 deficiencies. This situation also existed in Region IV and Region VI.

Review of Critical Elements

As in HCFA's 1982 review, our analysis also included an evaluation of deficiencies in critical requirements. Our analysis showed that 45% of facilities surveyed did not have a critical deficiency. This is down from 64% in the 1982 study. In 1982 only four regions had less than 60% of their facilities without critical deficiencies and three regions had over 75% of their facilities in this category. Our review revealed that all regions were below the 60% level and only one region was over 50%. It also appears that the variability between regions has also stabilized a bit. The national mean for facilities with no critical deficiencies is 44.9% with a range of a low 33.5% in Region I to a high of 54.4% in Region VI, a variation of only 21%. (Schedule 3)

Variations between states are quite evident. For example, in Region IV Florida and Kentucky, had over 70% of their facilities without critical deficiencies while Georgia and Mississippi had less than 35%. HCFA's study took notice of three states where the rate was extremely high. These were Wisconsin at 95%, Pennsylvania at 88% and Oregon at 89%. Our 1986 analysis showed these states rates of 43.6%, 50% and 44.1% respectively. The highest rate in our analysis was Maine at 72.2%.

Evaluation of State Surveys

An analysis of both deficiency levels reviewed can provide insight as to how a state surveys skilled facilities. We found that, for the most part, states that uncover a large number of deficiencies also report a large number of facilities with critical deficiencies. However, we also found that several states which had a low number of facilities with over 20 deficiencies had a high percentage of facilities with critical deficiencies. For example, North Carolina had identified only 7.9% of its facilities as having more than 20 deficiencies, yet critical deficiencies were reported in 53%. Similar situation ocurred in New York, Vermont, Tennessee, and Wisconsin. It should also be noted that remaining states with 20 or more deficiencies in less than 15% of their facilities reported a low percentage of facilities with critical deficiencies. (Schedule 4)

VARIABILITY ACCORDING TO FACILITY TYPE

Variation also occurred in regions and states according to facility type. In terms of total deficiencies this is quite apparent. Region I for example had 33% of its Medicare only facilities with 25 deficiencies yet only 14% of its Medicaid only were in this category. Conversely, Region VIII reported 32% of its Medicaid only facilities and 9% of its Medicare only at this level. In comparing Medicare/Medicaid facilities to Medicaid only facilities, five of the regions had more Medicare/Medicaid facilities with over 25 deficiencies and the other five had more Medicaid only facilities in this category. (Schedule 5)

In analyzing the types of facilities where critical deficiencies were found a consistent pattern developed. In every region with the exception of two (V & VII), there were more Medicaid only facilities with critical deficiencies. These results were almost identical to those reported in the 1982 study. (Schedule 6)

Our comparison of skilled and intermediate care facilities revealed an interesting pattern. Nine of the ten regions had fewer ICF with large numbers of deficiencies than SNF. However, eight regions had a greater percentage of ICF with critical deficiencies. Therefore this indicates that although large number of deficiencies were not uncovered in ICFs the deficiencies noted were more severe. (Schedules 7 & 8)

PERCENTAGE OF FACILITIES WITH OVER TWENTY DEFICIENCIES

	1982	1986
Region I	N/A	31.6
Region II	>50	32.6
Region III	<25	26.4
Region IV	<25	24.4
Region V	<25	24.9
Region VI	N/A	20.6
Region VII	N/A	41.3
Region VIII	>50	48.9
Region IX	>50	61.2
Region X	N/A	33.7

Note: 1982 data, if available, was only expressed in terms of greater than 50% or less than 25%.

Schedule I

PERCENTAGE OF FACILITIES WITH OVER TWENTY DEFICIENCIES IN SELECTED STATE

1982

Over 50%
- Connecticut
- New York
- Mississippi
- Colorado

Under 15%
- New Hampshire
- Tennessee
- Michigan
- Oregon

1986

Over 50%
- New Jersey
- Alabama
- Mississippi
- Indiana
- Kansas
- N. Dakota
- Utah
- Wyoming
- California
- Nevada

Under 15%
- New Hampshire
- New York
- Maine
- Rhode Island
- Vermont
- Kentucky
- N. Carolina
- Michigan
- Minnesota
- Texas
- Tennessee
- Wisconsin

Schedule 2

PERCENTAGE OF FACILITIES WITHOUT CRITICAL DEFICIENCIES

	1982	1986
Region I	<60	33.5
Region II	<60	44.8
Region III	>75	47.8
Region IV	N/A	49.3
Region V	>75	49.2
Region VI	N/A	54.4
Region VII	N/A	40.3
Region VIII	<60	45.7
Region IX	<60	35.1
Region X	>75	40.8

Schedule 3

COMPARISON OF TOTAL AND CRITICAL DEFICIENCIES [1986]

	% over 20	% with crit.		% over 20	% with crit.
	deficiencies			deficiencies	
New Jersey	71.7	65	New Hampshire	14.5	26
Alabama	53	75	New York	13	51
Mississippi	51	59	Tennessee	15	64
Indiana	56	59	Wisconsin	14	56
Kansas	51	83	Maine	11	28
N. Dakota	51	30	Rhode Island	5	43
Utah	78	51	Vermont	5	60
Wyoming	91	73	Kentucky	7	28
California	62	65	N. Carolina	8	53
Nevada	96	92	Michigan	11	27
			Minnesota	4	30
			Texas	7	29

Schedule 4

PERCENTAGE OF FACILITIES WITH OVER 25 DEFICIENCIES BY TYPE OF FACILITY

	Medicare ONLY	Medicare/ Medicaid	Medicaid Only
Region I	33.3	25.9	13.9
Region II	33.3	18.8	53.1
Region III	6.0	15.38	18.0
Region IV	7.7	15.3	19.8
Region V	15.6	18.4	6.8
Region VI	2.7	12.5	16.2
Region VII	21.7	32.1	26.0
Region VIII	9.1	33.2	32.4
Region IX	33.9	46.6	48.2
Region X	23.1	19.9	10.5

Schedule 5

PERCENTAGE OF FACILITIES WITHOUT CRITICAL DEFICIENCIES

	Medicare Only	Medicare/ Medicaid	Medicaid Only
Region I	33	34	31
Region II	38	47	29
Region III	50	49	38
Region IV	71	51	41
Region V	62	47	52
Region VI	70	62	39
Region VII	41	39	41
Region VIII	73	46	42
Region IX	52	34	29
Region X	54	42	36

Schedule 6

COMPARISON OF PERCENTAGE OF SNF AND ICF WITH OVER 20 DEFICIENCIES

	ICF	SNF
Region I	11.5	31.6
Region II	13.1	32.6
Region III	13.8	26.4
Region IV	12.4	24.4
Region V	20.1	24.9
Region VI	13.3	20.6
Region VII	12.5	41.3
Region VIII	38.5	48.9
Region IX	16.0	61.2
Region X	37.4	33.7

Schedule 7

PERCENTAGE OF FACILITIES WITHOUT CRITICAL DEFICIENCIES

	ICF	SNF
Region I	27	33.5
Region II	33	44.8
Region III	38	47.8
Region IV	36	49.3
Region V	23	49.2
Region VI	30	54.4
Region VII	48	40.3
Region VIII	31	45.7
Region IX	44	35.1
Region X	9	40.8

Schedule 8

[illegible]

Dave:

The following information is enclosed for your review:

- ---Sanctions available in Pennsylvania
  "Health Care Facility Act"
  Sections 811-817

- ---Facilities in Pennsylvania where a ban on admission was imposed and the license was not revoked.

- --- Summary of sanctions imposed in Pennsylvania
  1982--1986.

Should you have any questions, please contact me.

Pat Marion
[Office of the Inspector General, DHHS]

Sanctions Imposed on Pennsylvania Nursing Homes 1982--1986

1982	3
1983	4
1984	32 (1)
1985	98
1986	39 (2)

(1) January--June: 12
July--December: 20

(2) as of May 8, 1986

Facilities with Ban on Admissions without Revocation of License

Facility	Other Sanction
	provisional license IV
	provisional license I
	provisional license III
	provisional license I
	provisional license I
	provisional license I
	provisional license I
	provisional license I Fine

Section 811. Reasons for revocation or nonrenewal of license.

The department may refuse to renew a license or may suspend or revoke or limit a license for all or any portion of a health care facility, or for any particular service offered by a facility, or may suspend admissions for any of the following reasons:

(1) A serious violation of provisions of this act or of the regulations for licensure issued pursuant to this act or of Federal laws and regulations. For the purpose of this paragraph, a serious violation is one which poses a significant threat to the health of patients.

(2) Failure of a licensee to submit a reasonable timetable to correct deficiencies.

(3) The existence of a cyclical pattern of deficiencies over a period of two or more years.

(4) Failure, by the holder of a provisional license, to correct deficiencies in accordance with a timetable submitted by the applicant and agreed upon by the department.

(5) Fraud or deceit in obtaining or attempting to obtain a license.

(6) Lending, borrowing or using the license of another, or in any way knowingly aiding or abetting the improper granting of a license.

(7) Incompetence, negligence or misconduct in operating the health care facility or in providing services to patients.

(8) Mistreating or abusing individuals cared for by the health care facility.

(9) Serious violation of the laws relating to medical assistance or Medicare reimbursement.

Section 812. Provisional license.

When there are numerous deficiencies or a serious specific deficiency in compliance with applicable statutes, ordinances or regulations, and when the department finds:

(1) the applicant is taking appropriate steps to correct the deficiencies in accordance with a timetable submitted by the applicant and agreed upon by the department; and

(2) there is no cyclical pattern of deficiencies over a period of two or more years, then the department may issue a provisional license for a specified period of not more than six months which may be renewed three times at the discretion of the department.

Upon overall compliance, a regular license shall be issued.

Section 813. Right to enter and inspect.

For the purpose of determining the suitability of the applicants and of the premises or for determining the adequacy of the care and

SOURCE. HEALTH CARE FACILITY ACT

treatment provided or the continuing conformity of the licensees to this act and to applicable local, State and Federal regulations, any authorized agent of the department may enter, visit and inspect the building, grounds, equipment and supplies of any health care facility licensed or requiring a license under this act and shall have full and free access to the records of the facility and to the patients and employees therein and their records, and shall have full opportunity to interview, inspect, and examine such patients and employees. Upon entering a health care facility the inspectors shall properly identify themselves to the individual on the premises then in charge of the facility.

Section 814. Provider violations.

(a) Notice of violations.—Whenever the department shall upon inspection, investigation or complaint find a violation of this chapter or regulations adopted by the department pursuant to this chapter or pursuant to Federal law, it shall give written notice thereof specifying the violation or violations found to the health care provider. Such notice shall require the health care provider to take action or to submit a plan of correction which shall bring the health care facility into compliance with applicable law or regulation within a specified time. The plan of correction must be submitted within 30 days of receipt of the written notice.

(b) Appointment of master.—When the health care provider has failed to bring the facility into compliance within the time so specified, or when the facility has demonstrated a pattern of episodes of noncompliance alternating with compliance over a period of at least two years, such as would convince a reasonable person that any correction of violations would be unlikely to be maintained, the department may petition the Commonwealth Court or the court of common pleas of the county in which the facility is located to appoint a master designated as qualified by the department to assume operation of the facility at the facility's expense for a specified period of time or until all violations are corrected and all applicable laws and regulations are complied with, or the department in its discretion may proceed in accordance with this chapter.

Section 815. Effect of departmental orders.

(a) Enforcement.—Orders of the department from which no appeal is taken to the board, and orders of the board from which no timely appeal is taken to the Commonwealth Court, are final orders and may be enforced in the court of common pleas of the county in which the health care facility is located, or in the Commonwealth Court.

(b) Supersedeas.—Orders of the department, to the extent that they are sustained by the board, shall be effective, notwithstanding an appeal, unless the appellant obtains an order of supersedeas from the Commonwealth Court.

(c) Medical assistance payments.--Orders of the department, to the extent that they are sustained by the board, which fail to renew a license or which suspend or revoke a license, shall likewise revoke or suspend certification of the facility as a medical assistance provider, and no medical assistance payment for services rendered subsequent to the final order shall be made during the pendency of an appeal for the period of revocation or suspension without an order of supersedeas by the appellate court.

Section 816. Actions against unlicensed health care providers.

(a) Actions in equity.—Whenever a license is required by this chapter to maintain or operate a health care facility, the department may maintain an action in the name of the Commonwealth for an injunction or other process restraining or prohibiting any person from establishing, conducting or operating any unlicensed health care facility.

(b) Permanent injunction.—Should a person who is refused a license or the renewal of a license to operate or conduct a health care facility, or whose license to operate or conduct a health care facility is suspended or revoked, fail to appeal, or should such appeal be decided finally favorable to the department, then the court shall issue a permanent injunction upon proof that the person is operating or conducting a health care facility without a license as required by this chapter.

Section 817. Actions against violations of law, rules and regulations.

(a) Actions brought by department.—Whenever any person, regardless of whether such person is a licensee, has violated any of the provisions of this chapter or the regulations issued pursuant thereto, the department may maintain an action in the name of the Commonwealth for an injunction or other process restraining or prohibiting such person from engaging in such activity.

(b) Civil penalty.—Any person, regardless of whether such person is a licensee, who has committed a violation of any of the provisions of this chapter or of any rule or regulation issued pursuant thereto, including failure to correct a serious licensure violation (as defined by regulation) within the time specified in a deficiency citation, may be assessed a civil penalty by an order of the department of up to $100 for each day that such violation continues.

Section 818. Injunction or restraining order when appeal is pending.

Whenever the department shall have refused to grant or renew a license, or shall have suspended or revoked a license required by this act to operate or conduct a health care facility, or shall have ordered the person to refrain from conduct violating the rules and regulations of the department, and the person, deeming himself aggrieved by such refusal or suspension or revocation or order, shall have appealed from the action of the department to the board, or from the order of the board to the Commonwealth Court, the Commonwealth Court may, during pendence of such appeal, issue a restraining order or injunction *upon a showing that the continued operation of the health care facility adversely affects the well-being, safety or interest of the patients of the health care facility; or the court may authorize continued operation of the facility or make such other order, pending final disposition of the case, as justice and equity require.*

Section 819. Remedies supplementary.

The provisions of this chapter are supplementary to any other legal rights created in this act or any other act available for the enforcement of provisions of this act and rules and regulations promulgated thereunder.

Section 820. Existing rules and regulations.

(a) Continuation of rules and regulations.—Existing rules and regulations applicable to health care facilities not clearly inconsistent with the provisions of this chapter, shall remain in effect until replaced, revised or amended. In developing regulations, the department shall give priority to developing minimum standards for home health agencies and other health care facilities not previously subject to regulation. Sections 103.2 and 103.6 of Title 28 of the Pennsylvania Code are repealed.

(b) Expiration of licenses.—All health care providers licensed, approved or certified on the effective date of this chapter to establish, maintain or operate a health care facility shall be licensed for the period remaining on the license, certification or approval. If a health care facility has a license, approval or equivalent certification without an expiration date, it shall be deemed for the purposes of this section to expire one year after its date of issuance. At the expiration of the existing license certification or approval, the health care facility shall be subject to licensure pursuant to this chapter.

Section 8. Section 901 of the act, amended December 13, 1979 (P.L.532, No.118), is amended to read:

[Section 901. Certificates for existing facilities and institutions.

All health care providers operating a health care facility shall be issued forthwith a certificate of need by the department to all buildings, real property and equipment owned, leased or being operated under contract for construction, purchase or lease and for all services being rendered by the licensed, approved or certified providers on April 1, 1980: Provided, That this section shall not apply to a new institutional health service offered, developed, constructed or otherwise established after September 30, 1979 and before April 1, 1980 if the new institutional health service is covered by section 1122 of the Federal Social Security Act and application for approval is not made to or the project is disapproved by the Secretary of Health and Welfare.]

Section 901. Existing facilities and institutions.

No certificate of need shall be required for any buildings, real property and equipment owned, leased or being operated, or under contract for construction, purchase, or lease and for all services being *rendered by licensed or approved providers on April 1, 1980. Nor shall a certificate of need be required for any new institutional health services for which an approval has been granted under section 1122 of the Social Security Act or for which an application is found pursuant to such section to be in conformity with the standards, criteria or plans to which such section refers, or as to which the Federal Secretary of Health and Human Services makes a finding that reimbursement shall be granted: Provided, however, That such approval is in force on August 1, 1980 or such application shall have been filed prior to August 1, 1980 or the acceptance of applications for reviews under this act, whichever shall last occur.*

Section 9. Section 904 of the act is amended to read:

Section 904. Elimination of section 1122 reviews.

No further reviews shall be performed under section 1122 of the Federal Social Security Act, 42 U.S.C. §1320a-1, **[one year after implementation of reviews under this act.]** *after August 1, 1980 except to complete review for which application has been filed prior to August 1, 1980.*

Section 10. Repeals.

(a) Articles IX and X, act of June 13, 1967 (P.L.31, No.21), known as the "Public Welfare Code," are repealed insofar as they relate to health care facilities as defined in Chapter 8.

(b) All acts and parts of acts are repealed insofar as they are inconsistent herewith.

Section 11. Effective date.

(a) As to health care facilities defined in Chapter 8 of the act subject to licensure or approval pursuant to Article IX or X of the act of June 13, 1967 (P.L.31, No.21), known as the "Public Welfare Code," Chapter 8 shall take effect in 120 days and regulations affecting such health care facilities in effect on the date of enactment of this act shall remain effective until replaced or amended in accordance with this act.

(b) As to health care facilities defined in Chapter 8 of this act not subject to licensure or approval pursuant to Article IX or X of the "Public Welfare Code," Chapter 8 shall take effect in one year.

(c) Sections 103, 202, 502, 603(h), 701, 702(i) and (j), 707 (other than the introductory sentence), 708 and 709 shall take effect October 1, 1980.

(d) Section 10(a) of this act shall take effect in 120 days.

(e) The remainder of this act shall take effect immediately.

APPROVED—The 12th day of July, A. D. 1980.

DICK THORNBURGH

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date JUN 2 1986

From Director
Health Standards and Quality Bureau

Subject State Agency Direct Data Entry

To Regional Administrators
Regions I - X

We have been conducting State agency direct data entry demonstrations in 4 States for the past three years. We are now proceeding with expansion of this project to additional States in each region. We have sent the attached discussion paper to the ARAs of DHSQ for their review and comments, and also for nominations of States to be included in the first phase of the expansion.

Philip Nathanson

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date JUN 2 1986

From Sharon Harris

Sharon Harris, Acting Director
Office of Survey and Certification, HSQB

Subject State Agency Direct Data Entry - Position Paper

To Associate Regional Administrators
Division of Health Standards and Quality
Regions I - X

For the past three years, we have been conducting State agency direct data entry demonstration projects in Florida, South Carolina, Nevada and Washington. The attached paper discusses the results of these demonstration projects, our plans for expansion to additional States, and criteria for selection of these States. We have also included tentative or proposed policies and procedures for you and the States to follow during our second phase of the demonstration.

Before we expand to additional States, we need your comments on the general approach to the State agency direct data entry project in the areas of training, data entry, completion of records, and review and monitoring. In addition, we need your specific comments on the following questions:

1) Are there any areas that we have not discussed? What are they and what are your ideas about policies and procedures in these areas?

2) For States performing direct data entry, should L33 be automatically generated for unflagged cases after it has been determined that the State is entering cases accurately?

3) Should we allow the States to perform direct data entry on cases other than recertification actions? If so, how and when should these actions be phased-in?

4) Are the States in your region aware of the criteria, including COPs and critical requirements, which are used by MMACS to flag cases for review by certification specialists?

5) Is 100% review of the State's data entry for the first three month period appropriate? Is the time period too short or too long?

6) One of the ultimate goals of this project is to eliminate the flow of paper from the State to the RO. We have proposed that after 9 months at 90% accuracy, the State may be permitted to send only 50% of the cases to the RO. How long should this phase last? What should be the criteria for further reduction? At what point should the State be permitted to retain all cases?

7) We are considering allowing the States to update only certain fields in the provider records. These fields would include name, address, and number of beds. Deficiency tags would also be included to allow the States to enter revisits. We would not, however, allow the States to update any date fields. Do you have any objections to allowing the States in your region to update records and enter revisits?

We also need the names of States in your region which you feel should be included in this next phase of the project. Criteria for selection of States are included in the paper and should be detailed in your nominations. Please also include the name of a staff person who will be able to monitor and coordinate this project for your region.

I have been asked to take the lead for this project and I will be making the decision on States to be included and final policies and procedures. The Office of Program Support will be available for technical support and advice especially in the areas of computer hardware, software, and programming.

Please address your comments and nominations to Michael Moran by July 7. We will develop our final policies and procedures after we receive your comments, and will also notify you regarding the selection of States for this project. Any questions should be directed to Michael Moran on FTS 934-7903.

Attachment

Direct Data Entry Discussion Paper

Introduction

Since the MMACS was established in the mid-70s, State agencies have been responsible for forwarding certification kits to the ROs for review, approval, and data entry. This process has proven to be ineffective for the following reasons:

- State agencies are required to spend limited resources photocopying, collating, and mailing the required forms.
- Delays often occur between surveyor completion and regional office data entry because of the inability to read or understand the forms or incomplete/inaccurate information.
- Certification kits are sometimes lost or misplaced in transit.
- Increased data entry workloads with no corresponding increase in staff resources have severely strained the RO's data entry capabilities.

In an effort to improve the quality of the data, eliminate unnecessary paper flow, and increase cost effectiveness we plan on transferring the primary responsibility for the MMACS data entry from the ROs to the States. We hope this action will substantially reduce data entry errors, eliminate unnecessary paper flow, and provide more accurate and timely data. In addition, this should free the RO staff from the routine data entry functions, thus allowing them more time for review of substandard providers.

Demonstration

As a first step toward accomplishing this goal, we initiated a pilot study in 1983 to test the feasibility of allowing State agencies to enter the certification data into MMACS and to have direct access to the RADARS files for data retrieval purposes. In choosing the States for the demonstration project, we considered the size and diversity of their certification workload, their inhouse ADP capability and the recommendations of various regional offices who showed an interest in having one of their States participate in the project. Taking all these factors into consideration, the States selected for the study were South Carolina, Florida, Nevada and Washington.

At the start of the project, the Office of Program Support (OPS) supplied each of the States with a list of equipment with individual specifications for each unit. These specifications were compared with units that were currently operational in each of the pilot States. Using funds taken from the State survey budget, each State purchased additional hardware (microcomputers, monitors, printers, modems, etc.) and software which would be compatible with the IBM mainframe computer and which would also meet their needs for any inhouse data processing. In three of the test States (except for Washington) computer equipment was located in the agency headquarters. For Washington, however, multiple terminals were distributed among five of its field and zone offices to test the feasibility of networking among regional offices within large States. Once the equipment and software were procured and tested, the States were able to communicate with the HCFA Data Center via a dial-up line using the RENEX Protocol Converter. (The RENEX Protocol Converter allows communication among a variety of different vendor equipment by emulating the communication protocols of the various hosts.)

Briefly summarized below is a description of how the demonstration project is being conducted by the States and monitored by the regions.

Florida

The Florida State agency obtained one IBM-PC XT computer and accompanying computer hardware for its Jacksonville office. After the equipment became operational in January 1985, Atlanta provided onsite training to the State agency staff on RADARS and MMACS data entry techniques. When the training was completed, the project was implemented on April 22, 1985. Since that time, all the recertification kits for Florida's 1400 providers, with the exception of Intermediate Care Facilities for the Mentally Retarded (ICFs/MR), are entered by a data entry operator at the rate of six per day. Following entry of the kit, the RO calls up the records on the computer terminal and checks them for any obvious errors. The State is then responsible for making the necessary corrections after which they mail the hard copy documents to Atlanta. Throughout the course of the demonstration, the Atlanta RO reviewed a sample of kits to verify the accuracy of Florida's data entry. Based on an analysis of the error rates, Region IV concluded that the delegation of the data entry responsibility to the State did not erode the accuracy of the data.

South Carolina

The State agency purchased one Sperry 400 PC computer that is IBM compatible and is used in its Central Office which is located in Columbia. As with Florida, the Atlanta RO provided training for the State staff on RADARS and MMACS data entry. Effective May 20, 1985 the State began to enter the recertification kits of all its 395 facilities (except for ICFs/MR) into MMACS. The State mails the hard copies to the region after they correct all the errors. According to Region IV's analysis of the error rates, South Carolina's accuracy has steadily improved since the project began.

Nevada

Nevada selected a non-IBM computer (IMS 5000) that is used in its agency headquarters located in Carson City. In March 1985, the State began to enter recertification kits for its 120 facilities following MMACS and RADARS training by the RO. In addition to keying resurveys, the State also processes name and address changes as well as follow-up revisits. The State then mails the hard copies to the RO and about 50% of the kits are checked for accuracy by comparing the data displayed on the computer screen with the data keyed by the State. At this time, the RO is responsible for clearing the errors on the cases entered by the State. To date, Nevada has been doing an acceptable job of entering the cases accurately.

Washington

The Washington State agency obtained a variety of computer hardware including the IBM-PC XT and the IBM-PC terminals which are located in Washington's four field locations (Mt. Vernon, Spokane, Yakima and Seattle) and its agency headquarters in Olympia. (The placement of microcomputers in the field offices allows for word processing and data analysis capabilities and electronic transfer among terminal sites around the State.) In addition to the MMACS data entry and retrieval functions, Washington is also capturing additional data elements necessary to produce output reports to benefit the State licensing programs. Effective November, 1984, Washington State began doing direct data entry with most of the activity occurring in the Spokane office. (To date, a network has been successfully established between Spokane and Olympia with plans to expand the networks to the other three locations in the near future.) In addition to the entry of recertification kits for Washington's 637 facilities, the State is also responsible for correcting any errors for these transactions. The hard copies are then forwarded to the region where 100% of the kits are verified for accuracy by comparing the hard copies with the records on the terminal screen.

Conclusions

All parties involved in the tests agree that the State agency direct data entry project has been successful. South Carolina commented that since the recertification information is processed into MMACS more rapidly, there is a greater awareness on the part of the State for proper form completion. In addition, Region IV indicated the greatest selling point for the project is the States' access to RADARS since they have used the many reports available from the system and found them to be excellent.

On the negative side, the States do report some minor difficulties in the areas of communications, accessibility, and printing. For example, "garbage" on the telephone lines connecting them to the main computer sometimes prevents the States from entering data. In addition, the telephone line sometimes disconnects for no reason and the States occasionally need to dial the main computer repeatedly before a connection is made. Finally, the States report that they have print format problems with RADARS. However, they do agree that the advantages of direct data entry greatly outweigh the minor problems.

Expansion of Project

We plan to expand the direct data entry project to include up to 18 additional small to medium States by the end of calendar year 1986. This would include 2 States in each region not currently participating in the project, 1 each from San Francisco and Seattle and 2 from Atlanta. In order for both the Office of Computer Operations and HSQB-CO to monitor the effect of both the additional hardware and the additional users on the efficiency and effectiveness of the computer system, the additional States will be added gradually, beginning in August 1986. The ROs will nominate the States that they feel should participate in this project. Criteria for selection will include interest of the State in participating in the project, size and diversity of provider universe, the State's history of submitting accurate and complete certification information to the RO, and responsiveness of the State to RO requests. HSQB-CO will make the final decision concerning the States that will be included.

Current availability of IBM-compatible computer hardware in the States should also be considered. The additional cost for compatible hardware is estimated to be $10,000. Many States currently have hardware that is compatible, therefore, costs to these States would be nominal. Regional offices will approve additional hardware purchases within available regional allocations which will be sufficient to address these costs.

Direct Data Entry Policies and Procedures

As previously discussed, HSQB-CO did not set any uniform policies and procedures for the 4 States participating in the direct data entry project. The ROs involved worked with each State on an individual basis to establish these procedures. As a result, the type of cases entered, the number of cases reviewed by the RO and how and when they were reviewed, the error correction procedures, and the training procedures varied from region to region. This was done so that we could determine the best procedures from the experiences of the 4 States. However, before we expand the project, we will establish national policy for direct data entry. The following sections will discuss some proposed policies and procedures.

Training

The RO will be responsible for training State agency personnel in all aspects of the data entry process. If necessary, CO personnel from both OSC and OPS may be available as support staff subject to budgetary considerations such as availability of travel funds. All training will be conducted onsite at the State so that the State personnel can become accustomed to the use of their own equipment which will probably be different than the RO equipment. We recommend that the States be trained in RADARS first, and after they become comfortable in the use of RADARS, trained in MMACS data entry. In this way, the States can see how the information they will enter can aid them in areas such as survey management before they actually begin the data entry process.

Resources for training include the RADARS manual and the MMACS User's Manual which we are currently in the process of revising. In addition, the Atlanta RO has developed for the pilot project a CICS manual for the use of the States in that region and is willing to share it with other interested ROs. Please notify us if you would like a copy of the manual.

Training should include the following topics:

RADARS

- o TSO LOGON Procedures
- o Access to RADARS
- o Basic logic of the system
- o Available reports
- o Coding techniques
- o Uses of outputs

MMACS

- o CICS Logon procedures
- o Access to MMACS
- o Data entry
- o Inquiry

Following the initial six month period of State agency data entry, follow-up training should be conducted. Records of the numbers and types of State agency errors should be kept by the RO during this initial period since it will help to focus the follow-up training. If the RO has determined that the State can begin to correct errors, the training should include correction techniques, meanings of error codes, and the use of PF23 to view the cases with errors. (This last item will be necessary because the State will not be receiving any Individual Facility profiles.) (These instructions will be revised when the transaction file is eliminated.)

Also, if the RO has determined that the State can enter follow-up visits and changes to the MMACS record, the training should include the MMACS update function. Emphasis should be placed on the importance of correcting the data in fields that are not routinely entered for a recertification and that may have changed since the last recertification. Examples would include name, address and fiscal year end. Additional training may, of course, be conducted at the request of the State or when the RO determines that such training is warranted. We will also provide a more detailed recommended training agenda to the ROs after the States have been selected.

Data Entry

State agencies will have the responsibility for data entry of all recertifications for the following provider groups:

- Hospitals - accredited and unaccredited
- Skilled Nursing Facilities - Titles 18 & 19
- Intermediate Care Facilities
- Intermediate Care Facilities for the Mentally Retarded
- Home Health Agencies
- Independent Laboratories
- Rural Health Clinics
- Portable X-Ray Suppliers
- Ambulatory Surgical Centers
- Outpatient Physical Therapists
- Comprehensive Outpatient Rehabilitation Facilities
- Hospices
- End-Stage Renal Disease Facilities

We are limiting the type of action that the States will enter, at least initially, to recertifications so that the States will not be overwhelmed by the volume of data entry and the technical details associated with the various types of actions. We are considering allowing the States to enter other types of actions, possibly initials and adverse actions, in the future.

For all 18 and 18/19 providers and suppliers, States will enter the complete recertification kit which includes the Certification & Transmittal (C&T) (HCFA-1539), the appropriate Request for Certification, crucial data extracts for the health survey and Life Safety Code survey, where appropriate, and any statements of deficiencies. They will not, however, enter the following fields from the C&T:

L32 - RO Receipt of HCFA-1539
L33 - Determination Approval Date

(For ESRDs, they will enter everything on the Certification, Transmittal and Determination (HCFA-1540) through LC17 - State Agency Approval.) For Title 19 only providers, the States will enter the entire kit with the exception of L32 - RO Receipt of 1539. All complete kits (18, 18/19, and

19 only) will be forwarded to the RO in the usual manner as soon as data entry has been completed. Individual Facility Profiles (IFPs) will not be generated at the SA following data entry, but will be generated at the RO the next day. Since additional IFPs will be generated when L32 is entered by the RO, these first IFPs can be discarded.

Data entry of all major types of actions, including initials, CHOWs, and adverse actions will remain the responsibility of the ROs. Follow-up visits and other changes, such as name changes and changes in services, will continue to be entered by the RO during the first six month period. Following this initial period and based on SA performance, the RO has the option of allowing the State to enter follow-up visits and other changes to the MMACS records.

Completion of Records

L32, RO Receipt of HCFA-1539, will be entered into MMACS as soon as the kit is actually received in the RO. It is necessary for this field to be entered immediately to maintain the accuracy of the work processing times computed for Table 12 and the case control reports. L33, Determination Approval Date, will not be automatically generated for unflagged cases for any state performing direct data entry. It will therefore be necessary for the RO to enter this date in all Title 18 and 18/19 cases. (For Title 19 only cases, the State should be entering this date.) After L32 is entered by the RO, IFPs will be generated which will identify flagged and unflagged cases. Unflagged cases will require no additional review by program specialists and will allow the ROs to enter the approval date (L33) immediately. Flagged cases, of course, will require review prior to completion of L33.

Review and Monitoring

The State agency should send complete certification kits to the RO following data entry. (Since the State will be entering only recertifications, we do not anticipate that any kits will be rejected, requiring total re-entry. Therefore, it will not be necessary for the State to verify the data entry prior to forwarding the kit.) As we have previously discussed, the ROs must update the MMACS records when the kits are received in the RO in order to include L32. At this time, since the computerized data will already be available, the RO should verify the accuracy of the State's data entry by comparing the data on the computer screens with the data in the certification kit. It is especially important for the RO to verify that all deficiencies have been entered properly. This will be done for all kits entered by the States. This 100% review will be done for at least the first three month period. Following this period, if 90% of the cases reviewed are entered accurately, the review may be reduced to a 50% sample of cases. The RO should also be checking fields that are not routinely entered for recertifications such as name and address to see whether these fields have changed since the last recertification. During the first six months of data entry, the ROs must enter these changes since the States will not have been trained in the update function. The RO will keep a record of the numbers and types of data entry errors found as a result of this review.

In addition, for at least the first 6 month period, the RO will have the responsibility for correcting data fields that do not pass our edit and consistency checks. These errors should be corrected when the IFP is generated following the RO's entry of L32. A record of these errors should also be kept. After the 6 month period, if at least 90% of the cases entered did not have any errors (do not include any errors for L32 and L33 and any RO override errors (133 and 134) in your error rates), the RO has the option of allowing the State to correct its own errors. (These procedures will be revised when the transaction file is eliminated.)

As an additional monitoring activity, the RO should request that a specific sample of cases, such as all cases entered into MMACS on alternate Tuesdays, be forwarded to the RO in their entirety, which would include all appropriate survey report forms. This sample should be checked to determine if all deficiencies have been properly reported. This review could also be done as part of an onsite visit to the State.

After the State has been participating in the direct data entry project for at least 9 months, and is maintaining a 90% accuracy rate, the RO may permit the State to forward only 50% of the cases. However, the RO should continue to monitor the State for accuracy, and should either request that a sample of the other cases be forwarded to the RO on a regular basis for validation or review a sample of these cases during an onsite visit to the State.

Ultimate Goals of Project

In order to improve the data in the MMACS system, within the next three years we plan to transfer the responsibility for data entry of the bulk of the certification workload, which would include recertifications and follow-up visits, from the regional offices to all State agencies. We also plan to allow all State agencies to have direct access to RADARS. At the same time, in order to eliminate unnecessary paper flow, the State agencies doing direct data entry would retain all information concerning these cases in their offices. Computerized screens, similar to the critical requirement screens presently in place, would be used by the regional offices as a basis for certifications and automatically generate certification letters. This "paperless review" would free regional office staff from routine data entry and review, allowing them to concentrate their efforts on substandard providers and suppliers. Within this context, we also plan to mandate the use of hand held computers by surveyors during the survey process to directly transmit information about the survey to the State agency and the regional office. OPS is currently testing this concept in 2 areas. The Washington State agency is beginning to equip some of their surveyors with a 13 pound Morrow Pivot 2 Model 2522 portable computer to capture survey data and transmit this data directly to the HCFA Data Center. Also, OPS has a request from Nevada to assist them in the development of a similar proposal.

[COMMITTEE STAFF NOTE: Received from HCFA, Health Standards and Quality Bureau, June 10, 1986, in response to request for list of routine reports generated by Medicare/Medicaid Automated Certification System (MMACS).]

MMACS Routine Outputs

The following reports are generated by MMACS in a daily, biweekly, monthly and quarterly basis. They incldie:

Transaction File - Daily listing of those certification kits that had incorrect, incomplete, or inconsistent data that caused the data to be rejected when transmitted to MMACS. These kits remain on the transaction file until corrective action is taken by the region.

Table 1 - This listing is produced monthly and displays those facilities whose Time Limited Agreement will expire or annual survey cycle anniversary or deferred recertification date will occur in 120 and 150 days.

Table lA - An Individual Facility Deficiency History Profile containing complete provider identification data and both health and life safety code deficiency information from the five most recent surveys is generated monthly for each provider listed on Table 1 above.

Table 5 (Cases for RO Alert - formerly known as Overdue Recertifications table)

Table 5 is produced in four parts and contains the names and addresses of facilities whose recertifications were not processed into MMACS. The formula for determining whether the recertification case is due in the RO is based on type of provider. The criteria adopted for these reports are:

- General Accredited Hospital

  Cases that have a current survey date exceeding 36 months prior to the date of the report.

- All Other Non-LTC Facilities

  Cases having a current survey date exceeding 15 months prior to the date of the report.

- Medicare, Medicare/Medicaid SNFs

  Cases whose TLA dates or extension dates are due to expire within 45 days of the date of the report.

- Medicaid Only Providers

  Cases whose TLA dates or extension dates are 30 days prior to the date of the report.

Table 6 - This table is produced quarterly in two parts. Part one lists all participating LTC providers in chronological order by agreement ending date. Part two lists of all participating non-LTC providers in chronological order by annual survey cycle ending dates.

Table 6A - This table is produced quarterly in two parts (LTC and non-LTC). All certified Medicare/Medicaid health care facilities are listed in alphabetical order for ease of reference.

Table 8 - This table is produced quarterly and contains comparative deficiency data (State to region to national) at the Condition, Standard, and Element level. This data is a cumulative summary of the most recent surveys of record of all participating providers within a State. Each State is separately compared to the regional and national deficiency totals and percentages.

Table 10 - This table is produced quarterly and lists selected data from Table 8 in a frequency of deficiency format. Separate tables are produced for each type of provider by State showing those deficiencies which exceed the national average by 5 percent of more and the prefix tags are listed in descending order.

Table 12 - This table is produced quarterly and is a compilation of the average processing times for all State and regional offices involved in the certification process. The data describes the average time involved in processing a certification kit at each work station from survey to final approval. Only those certification kits that have been processed into the data base during the preceding quarter are included in the data for this table.

Table 13

An Individual Facility Profile (IFP) is generated following transmission and processing of each certification kit. This table contains complete provider identification data and health and safety deficiency information from the current and prior surveys. The IFP flags any critical requirement and/or condition level deficiencies as part of the front-end data entry process so that "flagged" recertification cases are forwarded to the specialists for indepth review.

Provider Counts - This table is produced biweekly and displays the number of certified providers and suppliers by State, region and the nation.

Report on RADARS Work Processing Table

```
RADARS (LONG TERM CARE)          AS OF 05/02/85; CONTROLS=0122299005 (ACTIVE PROVIDERS)     (TOTALS:STATE)                 05/09/85
                          MEDICARE, MEDICARE/MEDICAID SNF IN MASS APPROVED BY RO IN JAN 85

        SURVEY L34  PROV. L69 SVEYOR L19  STATE L20  HSQB  L32 DETERM L33 PUT-ON   L34   L34   L34
PROV     DATE   TO SIGNED  TO SIGNED  TO AGENCY  TO RECEIP  TO  DATE   TO COMPUT   TO    TO    TO
         (L34) L69  (L69) L19  (L19) L20  (L20) L32  (L32) L33  (L33) L67  (L67)   L32   L33   L67

225036 841031  28 841129  14 841212   6 841218   3 841221  19 850109  85 850404    51    70   155
225147 841030  14 841114  15 841129   0 841129   7 841205  35 850109  77 850327    36    71   148
225161 840914  34 841019  42 841130   0 841130   6 841207  52 850128  36 850305    84   136   172
225194 840503  38 840910 109 841228   0 841228  10 850107   2 850109  55 850305   157   159   214
225203 841109  28 841206   8 841214   0 841214   5 841219  21 850109  77 850327    41    62   139
225225 841128   0 841128  10 841207   7 841214   5 841219  21 850109  85 850404    22    43   128
225227 841012  32 841114  38 841221   0 841221  10 841231   9 850109  85 850404    80    89   174
225229 841015  26 841111  15 841126   4 841130   6 841205  54 850128  66 850404    51   105   171
225243 841025   7 841012  41 841123   4 841127   3 841130  41 850109  77 850327    35    76   153
225244 840923  28 841026  62 841227   0 841227  11 850107   2 850109  55 850305   101   103   158
225275 841001  30 841101  28 841129   0 841129  16 841214  26 850109  72 850322    74   100   172
225276 840927  47 841114  13 841127   0 841127  10 841206  53 850128  77 850415    70   123   200
AVERAGE DAYS:  28          33          2          6         28         71          67    95   166
```

```
RADARS (LONG TERM CARE)          AS OF 05/02/85; CONTROLS=0122299005 (ACTIVE PROVIDERS)     (TOTALS:STATE)                 05/09/85
                          MEDICARE, MEDICARE/MEDICAID SNF IN MASS APPROVED BY RO IN JAN 85

  REG  | L007< $ S018@ $ L033> $ L033<
  STE  |05       Z        841231  850201
       |
REGION TOTALS
       |
  01   |   234     118      2        12
```

Report 07 Name and Address Listing

```
RADARS-(HOSPITAL)                    AS OF 05/07/85; CONTROLS=0199101007 (ACTIVE PROVIDERS)    (TOTALS:REGION)                   05/09/85
                                 NAMES OF PEDIATRIC HOSPITALS IN REGION I

 PROV      N-A-M-E                               S-T-R-E-E-T                   C-I-T-Y / S-T-A-T-E           ZIP-CODE  TELEPHONE FISCAL
 073300 NEWINGTON CHILDRENS HOSP              181 EAST CEDAR STREET          NEWINGTON CT                  06111     2036662461  0930
 223300 JOSEPH P KENNEDY JR MEM HOSP          30 WARREN ST                   BRIGHTON MA                   02135     6172543800  0930
```

```
RADARS (HOSPITAL)                    AS OF 05/07/85; CONTROLS=0199101007 (ACTIVE PROVIDERS)    (TOTALS:REGION)                   05/09/85
                                 NAMES OF PEDIATRIC HOSPITALS IN REGION I
 REG    L007* & S263* T #017
  STE  01       5

 REGION TOTALS

 01        326        2      198
```

Report 08 (User Designed)

```
RADARS (INDEPENDENT LABORATORY)    AS OF 05/02/85; CONTROLS=0122506008 (ACTIVE PROVIDERS)    (TOTALS:STATE)                05/09/85
                                   MASS LABS APPROVED TO PERFORM HISTO + EST. TEST VOL FOR HISTOCOMPATIBILITY

PROV.# HISTO ETV      NAME AND ADDRESS OF LABORATORY

228031 01400 SMITH KLINE CLIN LABS INC LEARY LBS  343 WINTER ST             WALTHAM MA               02154
228137 00000 MEDIC CLINICAL LABORATORY            271 SALEM ST              MALDEN MA                02143
228220 02050 AMERICAN RED CROSS BLOOD SERVICES    812 HUNTINGTON AVE        BOSTON MA                02115


RADARS (INDEPENDENT LABORATORY)    AS OF 05/02/85; CONTROLS=0122506008 (ACTIVE PROVIDERS)    (TOTALS:STATE)                05/09/85
                                   MASS LABS APPROVED TO PERFORM HISTO + EST. TEST VOL FOR HISTOCOMPATIBILITY

REG    | L007= S S151= T #517
 STE   |06        1
       |
REGION TOTALS
       |
01     |   154         3    3450
       |___________________________|

***-FOLLOWING TOTALS REPRESENT ALL PROVIDERS THAT MET ALL CONTROL S SELECTION CRITERIA
```

Report 12 Current + 3 Prior Surveys

```
RADARS (INTERMEDIATE CARE FAC)    AS OF 05/02/85; CONTROLS=0122210012 (ACTIVE PROVIDERS)   (TOTALS:STATE)          05/09/85

 PROV.  LAST  SURVEY  PRIOR CUR-SURV-DEFS PREV-SUR-DEFS COMPLI.    CERT.  L067  CAT,CTL  3/RD-LATEST-SURVEY 4/TH-LATEST-SURVEY JULN
NUMBER ACTION  DATE  SURVEY TOT SRF CT  B TOT SRF CT  B S ELIG-CD  DATE   DATE  & FACTYP  Y/M TOT SRF CT  B  Y/M TOT SRF CT  B DATE
22E722 840530 630728 830412 009 006 00 01 005 005 01 01 A1      -1 790901 840105 10-16-07 8206   5   5  1  1 8105   9   9  0  3 3209

CUR-YR-DEFS T08473319 T08573319 T09164001 T09273319 T09373319 T15373319 K01873244 K05073251 K06273237

PREV-YR-DEF T02573167 T06063196 T11263196 T12573167 T12673167

3RD-YR-DEFS T08472215 T08572215 T10472237 T11672237 T11772167

4TH-YR-DEFS T07671182 T07771182 T08461347 T08561347 [T09061212] T09161212 T12971182 T14371182 T14471182

REPEAT-DEF'S: 084 085 091
```

T090 = Prefix tag on ICF Survey form
6 = Deficiency Status Code
5 = No Date of Plan of Correction
6 = Deficiency not corrected
7 = Deficiency corrected
80000 = Waiver
80000 = Deficiency uncorrected at time of revisit
9 = Provider refused to correct
1212 = Date of Correction expressed ~~in~~ as Julian date (212nd day of 1981)

Report 13 Individual Facility Profile

```
RADARS (LONG TERM CARE)          AS OF 10/01/85; CONTROLS:0330?99013 (ACTIVE PROVIDERS)    (TOTALS:STATE)                 [illegible]

****************************************************************************************** DATES -*************  MISC COUNTS -***
* 395307 (SKILL NURSING FACILITY)      * REGION/STATE (PHILADELPHIA  PENNSYLVANIA)  * PARTICIPATION      721001 * TOT REPEAT DEFS   4
* KENDAL AT LONGWOOD                   * COUNTY-CODE 710  *              [illegible]  * AUTHORIZATION      850707 * CURRENT  REPEATS  1
* BOX 100                              * SMSA -    "  445  * EDIT-ERRORS:000000000000 * SURVEY-COMPLETED   850708 * RECURRING REPEAT  3
* KENNETT SQUARE PA              19348 * SEA/REG   "       * TELEPHONE #:            * PROVIDER-SIGNED    850720 * INITAL F3C DOCS   _
**************************************** PSRO -    "  10   * MEDICAID ID:            * SURVEYOR-SIGNED    850708 * SEE FSC  DOCS     0
                                       * HSA -     "  PA001 * REPEAT-COND:NO         * STATE AGENCY       850711 * CONDS'S FSC DOCS  0
TYPE ACTION  2  RECERTIFICATION        * PARENT-PROV        * RECUR--COND:NO         * HSQB RECEIPT       850712 * NO PLAN OF CORR   0
RESURVEYS    10                        * SREF. PROV         * CURR SURVEY:FULL       * SURVEY REVISIT     [illegible] * PLAN OF CORR'S    0
OWNER CHG'S  00                        * PREV. INTER 50392  * PREV SURVEY:FULL       * DETERMINATION      850814 * DATE OF CORR'S    13
ELIGIBILITY: 1        (YES)            ********************** JULIAN SURVEY YDDD:5039 * PUT ON COMPUTER    850821 * WAIVERS           0
COMPLIANCE : A1       (YES)                                 * SURVEY TEAM:  1        * LAST ACTION        850819 * REFUSAL/DISCARDS  0
INTERMEDIARY 51390 AETNA                                    *  1 NURSES              * CHANGE OF OWNER    000000 *********************
TYP FACILITY 01 SKILLED NURSING FACILITY                    *                        * PRIOR-OWNER        000000
OWNERSHIP    12 OTHER   NON-PROFIT                          *                        * INTERMED. CHANGE          DEF - TOTALS & SURVEYS
TERM REASON                                                 *                        * TERMINATION                          ELS CONDS
ADVERSE ACT.   NO CURRENT ADVERSE ACTION                    *                        * FISCAL YR (MMDD) 0331  TOT SNF CRIT  P S STD
ADVERSE COUNT 0                                             *                        * CURRENT-SURVEY   850708  20  13   0  7  0  0
                                                            *                        * PREVIOUS SURVEY  840714   9   5   0  ?  0  0
                                                            *                        * 3/RD LATEST-SURV 830714   6   1   0  0  0  1
                                                            *                        * 4/TH LATEST_SURV 820204   5   ?   0  1  0  ?
*- - - - - - - -PROVIDER- -VARIABLE- -DATA- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -*

*-SERVICES (1=IN HOUSE,2=UNDER ARRANGEMT)                        LSC   MISC.-ITEMS (N/D NO DATA,N/A NOT APPLICABLE)
NURSING.......1                                           DATES DEF   1 LSF=1
PHY.-THERAPY..1                                    CUR.-LSC-SURV 841130  7   2 MED DIRECTOR DESIGNATION:BY FACILITY    ? 1?:PARTTIME
OUTPATIENT-PT.0   *-EMPLOYEES*    *---B-E-D-S-*    PREV.LSC-SURV 810214  6   3.S,N F. COVERED BY TITLE XIX WAIVER OF U.R.:NO
OCCUP.THERAPY.2       CERT.PART   TOTAL        38  3/RD-LSC-SURV 8?01?4  5   4 UTILIZATION REVIEW PERFORMED BY PSRO:NO
SPEECH PATH...2   RPN      8.50   CERTIFIED    56  4/TH-LSC-SURV 0112 ?  2   5.BASIS FOR FACILITY MEETING LIFE SAFETY CODE:
OUTPAT.-S.P...0   LPN      5.75   MEDICARE     56  LTC-BEGINNING 850501        ACCEPTS PLAN OF CORRECTION (A2)
SOCIAL-SERV...1   OTHER   37.75   MEDICAID      0  LTC-ENDING    860430      6.FULLTIME HEALTH SERV SUPERVIS.IS:N/D  ,QUALIFICATIONS
REC.-ACTIVITY.1     ENTIRE FAC    BOTH TYPE     0  LTC-EXTENDED                ARE:N/D
PHARMACY......2   RPN      8.50   SNF/ICF       0  BLDG.-PERMIT  7101        7.1981 LSC OVERRIDE:NO     8.PSRO BINDING REVIEW:N/D
CLINICAL-LAB..2   LPN      5.75   ICF OR IMR    0                            9.1967,1973 LSC FORM:YES 10.ICF/MR 15 BEDS OR LESS:NO
DIAGNOS.-XRAY.2   OTHER   37.75                                             11.MED.-DIRECTOR-HOURS:32 12.WATER SUPPLY:OTHER
BLOOD ADM/STR.0                                                             13.RN SUPERVISOR-HOURS:00 14.AUTO. SPRINKLER SYSTEM:AFF
DENISTRY......1                                                             15.RN SUPERVIS.-VISITS:00 16.SPRINKLER-SYSTEM MAINT:AFF
PODIATRY......2   CONDS-SURVEYED(1=Y)  HAZARDOUS AREA                       17.LSC PARTIAL-SURVEY:NO  18.SPRINKLER-FOR HAZ ...:AFF
OPHTHALMOLOGY.2   123456789012345678   123456789012                         19.CONSTRUCT-TYPE,SPRINKLER-CKED & LSC DEFF- (EACH FLOOR)
PSYCHOLOGICAL.0                                                                  4-340904-07
OTHER.........2   000000000000000000   333334444333

CUR-YR-DEFS F01475154 F05175154 F09675154 F11175154 F19375154 F27075154 F34675154,F41975154 F42175154 F42975154 F43075154 F43275154
  F44675154 K01775059 K01975090 K02?90000 K02575015 K0466?531 K04775074 K07675015

PREV-YR-DEF F10774046 F34674046 K01750000 K018?4097 K04650000 K05450000 K06464171 K06664090

3RD-YR-DEFS F01463097 K01750000 K05150000 K06463079 K06?63110 K0676?110

4TH-YR-DEFS F11172046 F22472036 F43272036 K01790000 K01872022

REPEAT-DEF'S: 346 014 111 432
```

Report 31 (Aggregate data)

```
RADARS (HOME HEALTH AGENCY)       AS OF 05/02/85; CONTROLS=9899305031 (ACTIVE PROVIDERS)  (TOTALS:REGION & NATION)       05/09/85
                                NUMBER OF PROVIDER BASED HHA'S BY REGION

REG     L007* & L061* O L061* O L061*
 STE    05       04       05       06

01         352         1       28        1
02         241         0       56       17
03         522         2      102       24
04        1055         2      107        8
05        1060         5      169       26
06        1012         7      221       43
07         509         2      128       14
08         241         4       64       10
09         447         1      110       20
10         142         0       50        5

TOTS      5581        24     1035      168
TOTAL PROVIDERS SELECTED =             1227
```

[COMMITTEE STAFF NOTE: On June 13, 1986 the Health Care Financing Administration published a final rule in response to a Federal court order in the case Smith v. Heckler, entitled "Medicare and Medicaid Programs Long Term Care Survey". See Federal Register pages 21550 through 21558.]

[COMMITTEE STAFF NOTE: Excerpts only of this document are included for brevity.]

DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service

Memorandum

Date

From Director, Division of Planning and Evaluation

RECEIVED JUN 24 1986

Subject HCFA Legislative Proposals

To OPD Directors

Attached are the FY 1988 legislative proposals prepared by HCFA. Would you please review these and let me know by telephone by Friday, June 13, if you have comments on specific issues. We can follow this up with written comments next Monday, June 16. Thanks.

L. Van Nostrand

Lyman Van Nostrand

Attachment

cc: Mr. Bastacky
Mr. Campagnoli
Ms. Crane
Ms. Johnson
Mr. McCloskey

DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service

Washington DC 20201

JUN 10 1986

TO: Mr. Cummings, ADAMHA
Ms. Katz, CDC
Mr. Van Nostrand, HRSA
Dr. Korper, NIH
Mr. Harrell, ODPHP
Ms. Blustein, NCHSR/HCTA

FROM: John P. Fanning, OHPE, PHS

SUBJECT: HCFA Legislative Proposals -- FY 1988 -- Review by PHS -- COMMENTS

Here are the FY 1988 legislative proposals of the Health Care Financing Administration. Would you please look at them and see if we need to say anything about them.

Please call Marcy Gross, 245-6301, by the end of the day on Friday, June 13, and let her know if you have comments. Even if you do not have a finished position, it is important to let Ms. Gross know generally what your comments are, so we can advise OS that we are going to say something. The details can follow, to be presented at the meetings on June 18.

Thank you for your prompt attention to this.

Attachment

cc:
Ms. Gross

DEPARTMENT OF HEALTH & HUMAN SERVICES
Office of the Secretary
Washington, D.C. 20201

JUN 10 1986

NOTE TO: Elizabeth Connell, ES (635G)
Richard Riseberg, PHS (4A53 Parklawn)
Ann Hunsaker, HCFA (5460N)
Sondra Stigen/Paul Spiegel, GC (435G)
Tom Ault, HCFA (339H)/Annette Coates
Trish Knight, L (416G)/Toni Davenport
Alissa Fox, MB (513H)
Steve Grossman, OASH (703H)/John Fanning
Randy Teach, ASPE (442E)
George Grob, ASPE (447D)
Bryan Mitchell, IG (5274N)

FROM : Cheryl Austein, ASPE CA
Room 424 E, HHH
245-6102

SUBJECT: FY 1988 HCFA Proposals

Attached is the FY 1988 legislative and regulatory program for the Health Care Financing Administration. I have scheduled a meeting to discuss staff positions on these proposals for:

Wednesday, June 18, room 446F
MEDICARE: 9:30 am
MEDICAID: 1:30 pm

In order to expedite the process, please submit a brief note to me by Friday, June 13 listing those items with which you concur and highlighting concerns on the remaining items. I will then share your comments with other team members early next week and the meeting can be used to focus on controversial issues.

Thank you for your cooperation.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date

From William L. Roper, M.D.
Administrator

Subject FY 1988 Legislative and Regulatory Program

To Robert Helms, Acting
Assistant Secretary for Planning and Evaluation

Attached is the Health Care Financing Administration's proposed legislative and regulatory program for FY 1988.

Our legislative and regulatory proposals are designed around several objectives or themes and are presented at tabs organized by theme. At each tab are: (1) a list of all the proposals in that section; (2) a summary and discussion of the proposals; and (3) an individual A-19 description of each proposal. The themes are:

- o promoting capitation in Medicare (Tab A) and Medicaid (Tab B)
- o reforming and refining Medicare reimbursement rules to achieve budgetary savings, increase equity and narrow the disparity between traditional, fee-for-service Medicare and pre-paid health care
  - — Physician services (Tab C)
  - — Part B non-physician services (Tab D)
  - — Outpatient departments (Tab E)
  - — Skilled nursing facilities (Tab F)
  - — Direct medical education (Tab G)
  - — Hospitals (Tab H)
- o assuring quality in Medicare and Medicaid (Tab I)
- o better targetting Medicaid benefits (Tab J)
- o administrative improvements (Tab K)
- o miscellaneous amendments (Tab L)

I look forward to expeditious consideration of our legislative and regulatory program. I would like to see agreements and issues identified quickly so that we can proceed with legislative drafting as soon as possible.

Attachments

Health Care Financing Administration
Fiscal Year 1988 Legislative and Regulatory Proposals

Tab A	Medicare Capitation
Tab B	Medicaid Capitation
Tab C	Physician Services
Tab D	Non-Physician Part B Services
Tab E	Hospital Outpatient Departments
Tab F	Skilled Nursing Facilities and Home Health
Tab G	Direct Medical Education
Tab H	Hospitals
Tab I	Quality Assurance in Medicare and Medicaid
Tab J	Better Targetting of Medicaid Benefits
Tab K	Management Improvement
Tab L	Miscellaneous Proposals

HCFA - 20

HEALTH CARE FINANCING ADMINISTRATION
FISCAL YEAR 1988 LEGISLATIVE PROPOSAL

Prospective Payment System for Medicare SNFs

Establish a Prospective Payment System for All Medicare Skilled Nursing Facilities

Current Law: Medicare services in skilled nursing facilities (SNFs) are reimbursed on a retrospective, reasonable-cost basis, subject to limits applied to routine operating costs (e.g., nursing, meals). Ancillary costs, such as physical therapy and drugs, and capital costs are not included in the cost limits.

- The limits are set at 112% of the average costs of urban and rural facilities for free-standing facilities. Hospital-based facilities face the same limit augmented by an add-on equal to 50 percent of the difference of mean costs between free-standing and hospital-based facilities.

The Consolidated Budget Reconciliation Act of 1985 gave skilled nursing facilities that provide fewer than 1500 days of Medicare covered days of care annually the option of accepting a prospective, flat rate payment equal to 105% of the mean routine operating and capital costs for all facilities. This payment is differentiated for urban/rural location, but not by hospital-based/free-standing. Facilities that choose this option may also file a simplified cost report. This provision will be effective October 1, 1986.

- The stated intent of this change was to increase beneficiary access to SNF services by creating incentives for facilities to seek Medicare certification and accept Medicare SNF patients, even though Medicare may provide only a small percentage of these facilities' total business.

Proposal: Establish a prospective payment system for all facilities providing Medicare financed SNF care. Medicare SNFs would be paid a facility-specific prospective rate based on actual routine operating costs for the prior year, up to cost ceilings.

- These cost limits would be set at 112% of mean routine operating costs for freestanding, urban/rural facilities, for three categories based on percentage of Medicare covered days of care among total days of care provided (0-9.9%, 10-40%, and over 40%).
  - The higher costs of hospital-based facilities would continue to be recognized by maintaining the present 50% add-on to the limits for these facilities.

- o Ancillary and capital costs would continue to be passed through (though an accompanying proposal would call for return on equity for proprietary facilities to be phased out once the prospective payment system was implemented).

In addition, request authority for the Secretary to implement a case-mix reimbursement system at his discretion.

Rationale: The proposal would put all Medicare SNFs on a prospective payment system. This would simplify the payment system overall by eliminating any need for retrospective rate adjustments. Facilities would benefit from being able to operate in a more stable and predictable economic environment.

In addition, use of "percent Medicare days of care" as a basis for categorizing facilities for the purpose of setting cost limits would establish the principle of case-mix related reimbursement for SNFs. HCFA research has indicated that percent Medicare days of care is the best proxy now available for a case-mix measure. We hope, once on-going research necessary for design of a case-mix measure is complete, to be able to replace percent Medicare days of care with a more sophisticated method of measuring case-mix differences, and this proposal would seek authority to implement this change once the research is complete and has been appraised, should such a change appear desirable at that time.

For the time being, use of percent Medicare days of care would help provide more adequate reimbursement to facilities that treat larger numbers of patients who are costlier to care for because of greater nursing and rehabilitation needs.

- o We favor using percent Medicare days of care rather than absolute numbers of days of care as the measure because the latter approach advantages small facilities without adequate justification. Encouraging large facilities -- some of which are already caring for significant numbers of Medicare patients -- to care for more Medicare patients is likely to increase overall SNF access more than encouraging small facilities to do the same.

Effect on Beneficiaries: The current system, even after the recent COBRA provisions, contains disincentives for facilities that are providing above 1500 days of Medicare covered days of care annually to expand Medicare services. Indeed, large numbers of "high volume" (over 40% Medicare) providers have costs at or above the current payment limits, a situation which could lead to cutbacks in services to Medicare patients. Yet these same "high volume" Medicare providers are those whose staffing ratios are higher and which are generally better qualified to meet the care needs of Medicare SNF patients.

Setting cost limits according to intensity of Medicare service provision would enable the Medicare payment systems to recognize case-mix related differences in patient care costs and thus would encourage greater access to care in those facilities already set up to serve the needs of Medicare SNF patients.

Cost: The proposal is effectively budget neutral.

Contact Person: Pamela Doty, HCFA/OLP, 245-0480.

TAB I

QUALITY OF CARE

Quality assurance is one of HCFA's most important functions. The budgets and personnel of the Health Standards and Quality Bureau and the Bureau of Quality Control, as well as those of our agents, the Peer Review Organizations and State survey and certification organizations, are dedicated to protecting and enhancing the quality of services to Medicare beneficiaries and Medicaid recipients.

This section contains five proposals which together seek to improve HCFA's capacity to monitor and enforce compliance with quality of care requirements in long-term care facilities. Two proposals are intended to improve the efficiency and effectiveness of the inspection of care (IOC) process. Two proposals seek to ensure that the survey and certification process is properly carried out by giving the Secretary authority to require State surveyors to meet qualification and training standards in situations where poorly qualified staff are contributing to inadequate surveys, and by permitting the HCFA to contract with private organizations to survey State-owned facilities. Another, technical proposal would eliminate a confusing provision in the law and clarify HCFA's intent to take rapid enforcement action where health and safety of patients is in jeopardy.

In addition to these proposals, two proposals specifically related to quality in health maintenance organizations are included in tab A. They are:

HCFA-6 Intermediate Sanctions
HCFA-7 Criminal Penalties

The FY 1987 legislative package contained several proposals focused on quality assurance. Two of them, PRO Denials for Substandard Quality of Care and PRO Termination Process, were included in the Consolidated Omnibus Reconciliation Act. Two others are included in the Administration's budget and administrative improvements bills, which are awaiting clearance at EOMB:

- o Promote Cost Effectiveness and National Consistency in the Operation of State Inspection of Care Programs (in the budget bill).
- o Impose Sanctions against Misleading Information to Medicare Patients (in the administrative improvements bill).

In the event that these proposals are not enacted, we will resubmit them in the FY 1988 package.

HCFA-25

HEALTH CARE FINANCING ADMINISTRATION
FISCAL YEAR 1988 LEGISLATIVE PROPOSAL

Utilization Control Inspection of Care

Add Utilization Control Penalty Requirements for Corrective Action

Current Law: Under current utilization control (UC) law States are required to conduct annual inspection of care (IOC) reviews for each patient in long term care facilities. The purpose of the IOC review process is to assure that each individual is made appropriately eligible for Medicaid long term care services and is receiving needed services in a facility certified to provide them. Enforcement of Federal Medicare and Medicaid facility requirements is a separate process and the responsibility of the survey and certification system. The objective of the survey and certification system is to assure that facilities participating in Medicare and Medicaid meet Federal health and safety requirements.

The UC statute requires that States be assessed fiscal penalties using an established formula for failure to conduct annual IOC reviews in accordance with requirements. As part of the IOC requirements the review team must prepare full and complete reports on deficiencies in the adequacy, appropriateness and quality of services provided to each patient. However, there is no provision in law for holding States accountable for ensuring that a facility take action to correct individual patient deficiencies identified by the IOC team. (A facility can be terminated under the survey and certification provisions for facility deficiencies.)

Proposal: Amend the Medicaid law adding an additional utilization control requirement to ensure that States have a corrective action plan for each facility which addresses identified patient deficiencies, and to require States to take all appropriate action to assure that facilities implement the corrective action. States that fail to take action to ensure that facilities implement correction action (the new requirement) would of course be subject to a UC penalty. However a 5 percent tolerance of the total identified deficiencies in a facility would be provided if States exercised good faith and due diligence in attempting to assure that the facility corrected at least 95 percent of the deficiencies and took steps to correct the remaining deficiencies within a reasonable period of team. The UC penalty would be applicable only when States failed to meet the tolerance provision.

Rationale: The current UC program holds States accountable for failure to conduct the IOC process in accordance with established requirements. However under current law a State is not required to make any effort to assure that patient care deficiencies uncovered during its annual reviews of each patient in every facility are corrected. An IOC process which identifies deficiencies but does not attempt to assure correction is ineffective because it does not ensure that there is improvement in the quality of patient care.

This proposal would make States accountable for taking appropriate actions to assure that facilities initiate corrective actions that result in an improvement in the quality of care problems noted by the inspection of care team.

Effect on Beneficiaries: Quality of patient care would be improved. No direct impact on coverage or cost of services to beneficiaries.

Cost (millions):

FY 88	FY 89	FY 90	FY 91	FY 92

Contact Person: Joyce Somsak, 597-1354

HCFA-21

HEALTH CARE FINANCING ADMINISTRATION
FISCAL YEAR 1988 LEGISLATIVE PROPOSAL

INTEGRATE INSPECTION OF CARE WITH MEDICARE/MEDICAID SURVEY AND CERTIFICA

Combine Inspections Processes in All Nursing Homes

Current Law: Sections 1902(a)(26) and (31) and 1902(a)(33)(B) of the Social Security Act provides for two types of review in SNFs and ICFs: (1) review of quality of care (2) facility inspections by a survey team to assure compliance with health and safety standards. Furthermore, Section 1902(a)(33)(A) of the Act provides that an appropriate State medical agency be responsible for the first type of review. Section 1902(a)(33)(B) provides that the State agency responsible for licensing health institutions be responsible for the second type of review.

Proposal: Integrate the Inspection of Care Review (IoC) with the Medicare/Medicaid Survey and Certification process in long term care facilities by requiring that both reviews be conducted by the State agency responsible for certifying health institutions. One team, consistently incorporating the appropriate qualified health professionals, can accomplish the purpose of both reviews.

Rationale: Under the current system, the division of responsibility for the two types of review has created a duplication of State review effort and a shortage of qualified surveyors to fill both teams. Both programs include a review of the same patient care services. The two reviews are performed by teams of health professionals and both require medical record review and observation and interview of patients and staff. Requiring one State agency to be responsible for both types of review would eliminate the inherent duplication of the current system and promote the more efficient use of personnel and other resources. The change would produce cost savings to the States in areas such as travel, staff support and overhead while concurrently reducing the time-consuming dual review burden now imposed on providers.

Effect on Beneficiaries: This proposal has no anticipated impact on beneficiaries.

Cost: (Millions) FY 88 - $5.0 (savings)

Effective Date: Six months after enactment

Contact Person: Sharon Harris 934-5547

HCFA-27

HEALTH CARE FINANCING ADMINISTRATION
FISCAL YEAR 1988 LEGISLATIVE PROPOSAL

ESTABLISH MINIMUM QUALIFICATION STANDARDS FOR STATE SURVEYORS IN PROBLEM STATES

Provide for Secretary's Authority to Set Minimum Qualifications for State Surveyors for Consistent and Effective Application of Medicare/Medicaid Regulations in States where Direct Federal Surveys have Uncovered Problems.

Current Law: The passage of Medicare and Medicaid legislation in 1965 caused the emergence of the Medicare/Medicaid health facility surveyor (individuals who inspect health care facilities to determine if they are in compliance with Federal health and safety standards). The Social Security Act provides no authority for the Secretary to establish minimum qualifications for surveyors. This lack of authority permits States considerable leeway in recruiting surveyors and setting State qualification requirements.

Proposal: To set forth minimally acceptable qualifications for individuals evaluating a facility's compliance with Medicare/Medicaid health and safety requirements. Imposition of these qualification requirements would be triggered by findings of skilled nursing and intermediate care facility activities conducted by the regional offices. These monitoring activities consist of onsite surveys by RO Staff and a review of the handling of State certification recommendations. If the Federal findings indicate that inadequate surveys are being conducted because of poorly qualified surveyors, the Secretary will require that surveyors hired in the future meet the training and experience qualifications prescribed by him.

Rationale: While the majority of State agency surveyors represent health professions, some States hire inexperienced and poorly qualified personnel. Also surveyors skilled in a limited area can be responsible for surveying components of a health facility outside the realm of their training. By providing the Secretary authority to set qualifications and training requirements for surveyors, we will assure a high quality surveyor essential to make complex determinations on patient health and safety.

Effect on Beneficiaries: This proposal will improve the quality of care in a safe and healthy environment in approximately 35,000 facilities affecting numerous Medicare/Medicaid beneficiaries. The change will be most significant in the Patient-Oriented Long Term Care Survey where the demands on the skills of the surveyor are most pronounced.

Cost: To be determined.

Effective Date: Six months after enactment

Contact Person: Sharon Harris, 934-5547

- HCFA - 28

HEALTH CARE FINANCING ADMINISTRATION
FISCAL YEAR 1988 LEGISLATIVE PROPOSAL

Eliminate the requirement to apply both terminations and the alternative sanction simultaneously in immediate jeopardy situations.

Current Law: The current statute requires the Secretary to impose the alternative sanction simultaneously with a termination action if a long term care provider no longer meets applicable conditions of participation or standards and its deficiencies immediately jeopardize the health and safety of the patients. Under section 1866(f)(1), a facility whose deficiencies are of the greatest threat to patients would arguably be entitled to a period within which to correct the deficiencies and, failing that, an opportunity for a hearing before the imposition of the alternative sanction. On the other hand, this procedure is wholly at odds with termination actions which become effective within 15 days' notice to the facility and which do not require hearings for the facility until after the termination has become effective. Thus, it creates substantial confusion to attempt to impose a sanction that contemplates the suspension of payments for new admissions after a relatively lengthy period at the same time that the Secretary is bound to terminate a facility's provider agreement (and thereby terminate funds for any beneficiary) in a very short period of time.

Proposal: To amend sections 1866(f) and 1902(i) of the Act which require the Secretary to apply both the termination and alternative sanctions simultaneously in immediate jeopardy situations. This would eliminate an unnecessary and confusing requirement in order to increase the effectiveness of our enforcement activities.

Rationale: A statutory amendment that would eliminate the need for the alternative sanction in immediate jeopardy situations would remove the confusion now created by the statute and would clearly reinforce Congress' expectations that the Secretary move quickly to protect the health and safety of facility residents in potentially hazardous situations through the expeditious termination of provider agreements.

Effect on Beneficiaries: None

Costs: None

Effective Date: Upon enactment

Contact: Sharon Harris, 934-5547

HEALTH CARE FINANCING ADMINISTRATION
FISCAL YEAR 1988 LEGISLATIVE PROPOSAL

HCFA - 29

Independent Surveys of State Facilities

Authorize The Use Of Independent Professional Surveyors To Survey Substandard State Owned Psychiatric Hospitals and ICFs/MR Participating in Medicare and Medicaid

Current Law: Section 1902(a)(33)(B) provides that the State agency responsible for licensing health institutions will perform the function of determining whether institutions and agencies meet requirements for participation in the Medicaid program. Under current law, States survey, certify and execute provider agreements for all Medicaid providers including those that are State owned and operated.

Proposal: Amend Section 1864(a) and 1902(a)(33)(B) of the Act and to require that if State owned psychiatric facilities and ICFs/MR are identified through Federal oversight (look behind, disallowance, complaint surveys, etc.) as having substantial deficiencies, all such hospitals and facilities within that State must be surveyed by independent professional surveyors approved by the Secretary of Health and Human Services and certified by DHHS in order to participate in Medicaid.

Rationale: In cases where a State owns and operates the provider, the State survey agency has little incentive to identify inadequacies in the provider's care and services. In order to preserve Federal Financial Participation, there is an incentive to maintain a provider's certification in spite of identified inadequacies. Survey findings may even be handled in such a way as to ensure certification. The proposal to permit HCFA to contract with independent professional surveyors to survey these facilities and to have HCFA make the certification decision would eliminate the existing potential for conflict of interest.

Effect on Beneficiaries: Beneficiaries will have greater assurance of the quality of services provided.

Cost: To be determined.

Effective Date: Six months after enactment.

Contact Person: Sharon Harris, 934-5547

responsibilities. This proposal includes these trusts since they generally fund extra goods and services not provided by Medicaid or other publicly funded programs -- an inequity, subsidized by the taxpayer, between those with and those without trusts.

HCFA-31 Increase eligibility penalties against individuals who transfer assets for less than fair market value.

States are now permitted to deny Medicaid for a period of time to persons who give away or transfer assets for less than fair market value. The State may consider transfers occurring up to two years before a person applies for Medicaid.

This proposal would require States to impose minimum penalties for such assets transfers, and would allow States to consider transfers occurring up to five years before a person applied.

HCFA-32 Simplify administrative aspects of the Medicaid spend-down.

Individuals may become eligible for Medicaid by deducting bills incurred for medical services from their incomes. Current law does not require the person to have paid those bills to qualify.

This change would require that bills be paid in order to be counted so that only persons whose income had actually been reduced by medical expenses would be able to qualify.

HCFA-33 Permit States to require spouses or parents of Medicaid recipients to contribute to the cost of their spouses' or minor children's care.

Institutionalized individuals from well-to-do families can qualify for Medicaid with no financial support required from their spouses or parents.

This proposal would permit States to require the spouses and parents of institutionalized recipients to contribute to the cost of care. States could set contribution amounts up to 20 percent of that part of the family's income that exceeds 200 percent of poverty. No contributions would be permitted for those with incomes below 200 percent of poverty (currently $22,000 per year); a family with income of $50,000 would pay no more than $5,600.

Proposing to increase family financial responsibility for long-term care is likely to be controversial, especially as it affects parents whose children face years of institutional care. However, there would be Federally-set maximum limits on the percentage of family income that may be required as a contribution, assuring that families would not be impoverished.

Also, family refusal would lead to the loss of eligibility. The severity of these consequences provides the incentive for the spouse or parent to pay the required support amount. Some will object that this provision makes the Medicaid recipient a hostage to family actions over which he has no control. States will have the authority to handle such hardship situations.

NOTE: This proposal is embodied in the Administration's FY 1987 HCFA "budget bill," now awaiting clearance at OMB. Should the provision not be adopted by Congress, it could be repeated as part of a package of targetting initiatives.

HCFA-34 Allow States greater flexibility in use of liens.

States use of liens is severely circumscribed by current law. States can impose liens on recipients' property before death only under limited circumstances: if the recipient is institutionalized, is unlikely to ever return home, and is without a spouse, child, or sibling residing in the home.

This proposal would remove these restrictions and increase the States' ability to impose liens on the property of institutionalized Medicaid recipients, further facilitating State efforts to recover from the estates of Medicaid beneficiaries.

Once commonly used by States, particularly on the homes of welfare recipients, liens fell out of favor because they discouraged people in genuine need from applying for benefits. In Medicaid, such an effect could conceivably lead to inadequate care. However, the provision would be limited to persons in institutions who are presumably so disabled and lacking in personal resources to pay for their own care that they have little room to refuse to accept Medicaid conditions.

HEALTH CARE FINANCING ADMINISTRATION
FY 1988 LEGISLATIVE PROPOSAL

HCFA-33

Financial Responsibility of Spouses and Parents

Permit States to require spouses or parents of Medicaid recipients to contribute to the cost of their spouses' or minor children's care.

Current Law: Thirty-six States use SSI rules for all aged, blind, and disabled Medicaid recipients. In these States, income of parents and spouses of Medicaid applicants or recipients must generally be deemed to be available to their spouses or children if they live in the same household, but not if they live apart, for example if the spouse or child lives in an institution. (The other 14 States — the so-called "209(b)" States — are not required to follow SSI rules.) At State option, families may also be relieved of any financial responsibility for recipients of Home and Community Based waiver services and for disabled minor children who are at risk of institutionalization but for whom home care is an appropriate alternative.

This all-or-nothing rule, based on where the recipient lives or what kind of care is needed is believed to encourage institutionalization and is inequitable. It also contributes to escalating Medicaid costs for long term care by shifting costs for long term care from financially able spouses and parents to the taxpayer. And current rules contribute to the perception of welfare abuse when people from well-to-do families get full Medicaid coverage of long term care.

All States have general statutes requiring husbands to support their wives and parents to support their minor children. All but a few also require wives to support their husbands. However these laws are often enforced weakly or not at all with respect to Medicaid recipients in institutions. This occurs because enforcement procedures which are consistent with Medicaid statute are difficult and costly to administer and not always effective at eliciting the required contribution. In essence, the State must "pay-and-chase", meaning additional case development outside the usual Medicaid eligibility process, pursuing cases through family court, and often other legal action.

Proposal: Permit States to impose and effectively implement requirements that financially able spouses and parents contribute to the cost of care for their spouses and minor children in three situations when they do not now contribute; that is, when the Medicaid eligible spouse or minor child (1) resides in a Medicaid institution, (2) receives services under a Home and Community Based waiver, or (3) is a disabled child deemed eligible under Section 1902(e)(3) of the Social Security Act.

- States would establish contribution amounts except that they could not require families to contribute more than 20 percent of the amount by which family income exceeds 200 percent of Federal poverty guidelines.
- Failure to make the required contribution would result in the loss of the child's or spouse's Medcaid eligibility.
- Contributions would be paid to the State, not collected by the medical institution.

HCFA-39

HEALTH CARE FINANCING ADMINISTRATION
FISCAL YEAR 1988 LEGISLATIVE PROPOSAL

ALTERNATIVE SANCTION: ELIMINATION OF THE INFORMAL HEARING

Conform Due Process Requirements of Alternative Sanction to Those of Termination

Current Law: Section 1866(f) of the Social Security Act requires that the provider be given: an opportunity to correct; notice and an informal hearing, and notice of the hearing decision, before payments for new admissions may be denied. However, before termination action pursuant to Section 1866(b) of the Act is taken, the provider is given an opportunity to correct and 15 days notice. An evidentiary hearing before an administrative law judge is afforded after the effective date of the termination. An informal hearing before termination is not given.

Proposal: Conform the due process requirements of the alternate sanction to those afforded for termination action.

Rationale: The alternative sanction is the less detrimental than termination to the provider and thus it is not reasonable that due process should be greater for the lesser sanction. Moreover, the process as required by the current provision takes longer to complete the termination process. This means that the provision cannot be used in the interim between survey and termination, which would be a very effective way to use the provision. Also, some courts have interpreted Section 1866(f) as requiring an informal hearing before termination action, reasoning that it makes sense that informal hearing applies to terminations if it is required for the lesser sanction. If the provision is to be effective it must be freed of the encumbrance imposed by the informal hearing.

Effect on Beneficiaries: The quicker the denial of payments is imposed, the fewer the number of beneficiaries that will be exposed to potentially substandard care and services. Moreover, the quicker the ban is imposed the greater the incentive for the provider to achieve compliance.

Cost: None.

Effective Date: Upon enactment.

Contact Person: Sharon Harris, 934-5547.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

6325 Security Boulevard
Baltimore, MD 21207

JUN 25 1986

Ms. Julie Trocchio
American Health Care Association
1200 15th Street, N.W.
Washington, D.C. 20005

Dear Ms. Trocchio:

Thank you for bringing to our attention some of the problems that have arisen following our policy issuance on the consultative role of surveyors. I also appreciate your recommendations for clarifying the policy. Enclosed for your information and distribution is a reiteration of the policy which I hope will remedy misunderstandings. We will be distributing the clarification to our States and regional offices.

Sincerely yours,

Sharon Harris
Acting Director
Office of Survey and Certification

Enclosure

cc:
Ms. Elma Holder
Mr. John Jarrell
Mr. Jim Marrinan

Consultative Role of Surveyor

The survey and certification process is intended to ascertain whether or not providers and suppliers meet program participation requirements. Therefore, the primary role of the surveyor is to assess the quality of care and services and to relate those findings to statutory and regulatory requirements.

When deficiencies are found in the course of a survey, the surveyor is asked to carefully document the findings. The surveyor should explain to the provider what the deficiency, is in terms specific enough to allow a reasonably knowledgable person to understand why the requirement is not met. In many situations, the explanation itself will provide the action needed to correct the problem. If the cause of the deficiency is obvious to the surveyor, that information should be shared with the provider. We do not consider this to be consultation.

However, in some instances there may be several possible causes for the deficiency and it is for these situations that the consultation policy is intended. It is not the surveyor's job to delve into the facility's policies and procedures to determine or speculate on the root cause of the deficiencies, or to sift thorugh various alternatives in an effort to prescribe one acceptable remedy. In these situations, the provider is responsible for determining the most feasible and the economical way of achieving compliance.

On resurvey, the surveyor's task is to ascertain whether or not compliance has been achieved, not whether the provider did what the surveyor recommended. Thus, in reviewing a proposed plan of correction the State agency should only be reviewing the plan for effectiveness and timeliness. Corrective action only has to work.

The policy on consultation was revised because the emphasis by surveyors on consultation philosophically and logically conflicted with the revised termination procedures. Consultation was being taken to an extreme. It was being used to delay action required by law. Beyond that, consultation conveyed the idea either that providers are not expected to know what the requirements are or, that the requirements are too complex. Another implication, and one of even more concern to us, was that the Federal and State Governments, not the providers, are somehow responsible for ensuring that providers achieve and maintain compliance.

On the other hand, we are not saying that survey agencies should refuse to meet with provider associations, nor are we trying to preclude meaningful exchanges of information between surveyors and the providers. In all cases, surveyors should be willing to explain the requirements and why what they did or did not find requires correction. For example, if a provider were cited for maintaining incomplete clinical records, the surveyor should specify what is missing--not why it is missing or what process is the best for ensuring that the records will be complete in the future. Under no circumstances should a data tag or a reiteration of the regulations be used as a substitute for an explanation.

State agency staff should be willing to work with all groups within their State if such discussions or meetings will lead to more meaningful surveys, or an overall improvement in the compliance of providers and suppliers.

[COMMITTEE STAFF NOTE: On July 3, 1986 the Health Care Financing Administration published a final rule entitled "Medicare and Medicaid Programs; Intermediate Sanction for Long Term Care Facilities". See Federal Register at pages 24484 through 24493.]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of
Human Development Services

Office of Assistant Secretary
Washington DC 20201

MEMORANDUM TO: The Secretary JUL 10 1986

THROUGH : US ________
COS ________
ES ________

FROM : Acting Commissioner on Aging

THROUGH : Jean K. Elder, Ph.D. Jean K. Elder
Acting Assistant Secretary for
Human Development Services ________

SUBJECT : Administration on Aging Response to
the Institute of Medicine Report

Background

The Institute of Medicine (IoM) study on the quality of life in nursing homes has a primary focus on issues related to programs administered by the Health Care Financing Administration (HCFA). A portion of this study is devoted to the Older Americans Act long term care ombudsman program.

The Administration on Aging (AoA) has analyzed the Study Committee findings and is submitting its comments for your consideration. AoA's comments have been shared with HCFA staff and they have indicated general agreement with the AoA recommendations.

In Attachment A, you will find study recommendations pertaining to the ombudsman program and AoA's recommended responses to each of the recommendations. Attachment B provides a brief history of the ombudsman program.

Carol Fraser Fisk
Carol Fraser Fisk

Attachments

ATTACHMENT A

INSTITUTE OF MEDICINE
RECOMMENDATIONS RELATING TO THE
OLDER AMERICANS ACT NURSING HOME OMBUDSMAN PROGRAM

Chapter 1 - Introduction and Summary - (pp. 41-42)

Recommendation 6-1

HCFA should require States to make inspection reports accessible at nominal costs to consumers and long term care ombudsmen.

Response HCFA is responding to this recommendation in its report. AoA recommends that the reports be made available in the community, without cost, to either the ombudsman or the consumer. The process for making the report available to the consumer will be included in the HCFA recommendatons. HCFA and AoA have discussed ways to insure that inspection reports will be provided to the long term care ombudsman upon a formal request.

Recommendation 6-2

The Older Americans Act should be amended to incorporate the following items:

o A new, separate title should be created for the ombudsman program--

Response We oppose creating a separate Title for the Ombudsman program as we see nothing to be gained by doing so. The program is funded under Title III of the Older Americans Act and through State and local resources, with the major portion of support coming from Federal Title III funds. The amount of Title III dollars devoted to the program is based upon the overall funding formula to States for Title III. Creation of a new Title would add more complex Federal requirements for the administration of the program.

o The base funding requirement should be increased from the current 1 percent of the State's annual Title III allotment or $20,000, whichever is greater, to an annual minimum requirement of $100,000 plus an additional amount based on number of older persons in the State--

In addition, the report recommends an increase from the current 85/15 Federal/State matching ratio to a new 2/3 Federal to a 1/3 State share--

Response We recommend no change in the current funding requirements. The current legislation sets forth a minimum requirement or a "floor" for State expenditure and give States maximum flexibility as to how much more they want to invest in the program. An increase in Title III funding is not anticipated; therefore, an increased minimum expenditure would result in a reduction of expenditure for ongoing programs.

We oppose the increased matching ratio because it introduces a different funding formula for a particular Title III service which would result in considerable administrative confusion.

o The establishment of a National Advisory Council with State Ombudsmen, State and Area Agencies on Aging, service providers, consumers, State regulators, health care professionals to advise on administration, training, priorities, research, and evaluation--

Response We oppose formulating another separate advisory committee for the ombudsman program. We recommend that legislative language be added to the Federal Council on Aging's responsibility to include concern about quality of care in nursing homes.

o Authorization for State certified ombudsman to access nursing homes and with the permission of the resident to a resident's medical and social records--

Response We support this recommendation because ombudsmen must be able to enter nursing homes during reasonable visiting hours and have access to residents and resident information if they are to function effectively. Even though the Older Americans Act already contains this provision, some ombudsmen have encountered problems in accessing some facilities. Comparable provisions must be added to HCFA policy and legislation to insure that nursing homes permit ombudsman access.

Currently, the Older Americans Act does not address the issue of certifying ombudsmen. We favor adding legislative provisions for State certification of ombudsmen staff. This would give credentials to staff who have access to residents and resident records.

Since this program relies heavily upon volunteers, hopefully, such a provision would increase the professionalism, credibility and stature of the program and would encourage greater State responsibility for training ombudsmen staff.

- Authorize public legal representation--

Response The intent of this recommendation is not discussed in the report; however, it appears that ombudsmen need to have access to legal advice on an "as needed" basis. Since the discussion on this point is vague, we have no response for this item.

- Exempt ombudsman programs from OMB A-122 antilobbying provisions--

Response We are not taking a position on this recommendation to support or oppose it because the provision has very limited application. There is confusion about who is subject to these provisions under what conditions. A-122 Cost Principles only apply to private, non-profit grantees. Since the majority of ombudsmen are State or local government employees, they are not governed by the A-122 cost requirements. If there are issues related to this provision, these situations should be resolved on a case by case basis.

Recommendation 6-3

The HHS Secretary should direct AoA to provide effective national leadership for ombudsman programs through: 1) full time professional and support staff; 2) establishment of a national resource center/information clearinghouse to develop training and other materials to assist States; 3) guidance on data collection and analysis; 4) establishment of program priorities; and 4) sponsoring research and evaluation studies.

Response Since its inception, AoA has given a high priority to quality staffing of the ombudsman program. Presently, two full-time, senior aging program specialists with extensive medical background and experience in community and institutional long term care, work with this program in the Office of State and Tribal Programs. Also, a senior staff person in the Office of Program Development with a strong medical background and extensive experience in HCFA funded programs works full time on long term care concerns. In each of the ten Regional Offices, a full time person serves a Regional liason for this program.

Relative to the resource center/clearinghouse recommendation, AoA no longer has a formal national clearinghouse on aging nor do we provide comprehensive information about specific program services. Instead, the demand for information sharing is met through staff assistance especially through our Regional Offices, information memoranda, and aging program notes which relay best practices and innovative program approaches.

Recommendation 6-4

HCFA should require State regulatory agencies to develop written agreements with State ombudsman programs regarding information sharing, training, and case referral.

Response We support the establishment of requirements which link HCFA State Agencies and State Agencies on Aging. The information collected by the ombudsman program needs to be incorporated into the nursing home review process. Information about issues and changes in HCFA requirements should be provided to State Agencies on Aging on a regular basis. AoA and HCFA staff met to discuss potential areas for future collaboration, particularly in the area of training. Plans will be formulated following final action on the IoM study recommendations.

ATTACHMENT B

HISTORY OF AoA'S LONG TERM CARE OMBUDSMAN PROGRAM

In the late 1960's, nursing home reform became a major issue for many private and public organizations and groups. In the early 1970s, the Federal multi-point nursing home reform program included provisions for long term care ombudsman demonstration projects. In 1972, AoA awarded seven contracts to six State Agencies and one national organization for two and three year long term care ombudsman demonstrations. The demonstrations projects established model ombudsman programs to:

- investigate conditions in nursing homes;
- determine and work to resolve complaints made by or on behalf of nursing home residents; and
- resolve legislative and systemic problems relating to long term care.

The 1975 Amendments to the Older Americans Act, authorized the Administration on Aging (AoA) to make grants to all States for the development of ombudsman demonstration projects. The focus of the demonstration projects was to create State ombudsman programs for complaint resolution. The 1978 amendments to the Title III program under the Older Americans Act required each State to establish a long term care ombudsman program. Each State is now required to use at least 1 percent of its annual Title III-B Supportive Services allotment or $20,000 whichever is greater, or such amount above the minimum that the State Agency determines to be adequate, to operate a long term care ombudsman program.

Each State is responsible for operating directly, or by contract or other arrangement, a long term care ombudsman program which provides a full time ombudsman who will:

- Investigate and resolve complaints made by or on behalf of older residents of long term care facilities;
- Monitor the development and implementation of Federal, State and local laws, regulations and policies affecting long term care facilities in the State;
- Provide information to public agencies regarding the problems of older long term care residents; and
- Train staff and volunteers and encourage citizen particpation in the program.

States must establish procedures for appropriate access by the ombudsman to long term care facilities and patient records, including procedures to protect the confidentiality of such records. There must be assurance that the identity of any complainant or resident will not be disclosed without the written consent of the complainant or resident, or upon a court order.

Each State is required to establish a Statewide uniform reporting system to collect and analyze data about the complaints and conditions in long term care facilities. This information is to be used to identify and resolve significant problems. Such information is to be submitted to the State Agency responsible for licensing or certifying long term care facilities and to the Commissioner on Aging on a regular basis.

The Title III provisions also require each Area Agency on Aging to facilitate the involvement of long term care providers in the coordination of community based long term care services and to ensure community awareness and involvement in addressing the needs of residents of long term care facilities.

There is considerable diversity as to how States administer the ombudsman program. Part of this diversity stems from how the State is organized internally. Demographic and geographic factors also affect State policies and procedures for administering the program. This same diversity is reflected in community based ombudsman programs. Factors such as the size of the State, number of elderly, number of facilities, number and characteristics of elderly in long term care facilities and rural/urban/suburban location of facilities influence the type of program in each State. Some States have enacted specific ombudsman legislation. Other States do not have specific legislation; however, they have laws increase the authority and responsibility of ombudsmen.

Local ombudsmen programs increased from 503 in 1982 to 679 in 1984. About 50 percent of the local programs are administered by Area Agencies on Aging. Funding of Ombudsmen programs increased from $10.4 million in 1982 to $14.3 million in 1984. State level funding increased by 25 percent and local level funding increased 46 percent. In 1982 approximately 3.8 percent of Title III-B Supportive Services funds were used for the program and in 1984 approximately 5.1 percent of the Title III-B funds were used for this purpose by the 52 States participating. Title III-B funds represented a major share of total resources. In 1982, Title III-B represented 63 percent of the total resources used and in 1984, Title III-B funds represent 66 percent of the total cost. State and local paid staff and volunteers totaled 6,258 in 1984, which is an increase of about 50 percent since 1982. About 80 percent of the local program staff are volunteers.

The number of complaints received increased from 40.727 in 1982 to in 71,128 in 1984. Of the 71,000+ complaints reported, 67 percent were partially or fully resolved. The majority of complaints focused on poor food, poor personal care, loss of personal items, staffing problems, Medicaid discrimination and other similar complaints.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

[JUL 25 1986]
JUL [illegible] 1986

Memorandum

Date

From Sharon Harris, Acting Director
Office of Survey and Certification

Subject State Funding for Long-Term Care Survey Activities

To Associate Regional Administrators
Division of Health Standards and Quality
Regions I-X

The State survey budget for FY 86 included funding for a 10 percent in-depth sample of residents in skilled nursing facilities and intermediate care facilities. As you are aware, in our unit cost budget methodology, we increased time parameters for the inspection of long-term care facilities which should allow surveyors to conduct a larger sampling of residents. The budget for long-term care surveys in FY 87 has been increased from the FY 86 level to accommodate these time parameters, and States will have sufficient monies to permit a review of a 20 percent in-depth sample of residents.

We, therefore, expect States to expand their sample sizes to 20 percent of the resident population in SNFs and ICFs beginning next fiscal year. If States have an inadequate number of staff to handle the increased workload, we encourage them to hire additional personnel if at all possible. As an alternative to hiring permanent staff, States may wish to consider subcontracting with individuals.

ROs should convey this information to their States and ensure that they include planning for this activity during upcoming FY 1987 budget negotiations so that they will be able to carry out the additional resident reviews beginning October 1.

cc: Regional Administrators
Regions I-X

DEPARTMENT OF HEALTH & HUMAN SERVICES
Office of Inspector General

Memorandum

Date July 28, 1986

From Richard P. Kusserow
Inspector General

Subject OIG Audit Report - Use of the Medicare/Medicaid Automated Certification System by the Health Care Financing Administration - ACN: 03-60154

To

William L. Roper, M.D.
Administrator, Health Care
Financing Administration

Attached is our final audit report on the Health Care Financing Administration's (HCFA's) use of the Medicare/Medicaid Automated Certification System (MMACS). In our report we pointed out that MMACS was not a fully effective management tool because the information it contained was often outdated and, therefore, not as useful as it should have been. We recommend that HCFA get MMACS current, keep it current and use it to plan and develop national strategies aimed at improving conditions found in the nation's nearly 20,000 nursing homes providing care to 1.75 million Medicare and Medicaid patients.

HCFA responded that our report was useful and would be incorporated into the overall effort to improve the accuracy and timeliness of MMACS data. The list of improvements is impressive, particularly HCFA's plan to implement a "paperless process" in which surveyors will use hand-held computers to collect information and transmit it to the States and regional offices. Once HCFA's ultimate goal is achieved, keeping MMACS current will no longer be a problem.

What will remain a key issue, however, is how HCFA intends to use an improved and updated MMACS. Although HCFA did not specifically respond to our recommendation dealing with this issue, there are indications that HCFA intends to use MMACS more as an evaluation device for measuring regional office performance rather than as a planning device for developing national strategies. We believe it is very important that MMACS be used as a planning device to assist HCFA top management identify problems, establish priorities, and develop projects aimed at eliminating problems affecting the health and safety of nursing home patients.

We would appreciate receiving any additional views you may have on this matter, and within 60 days, an update on any further action taken or contemplated on our recommendations.

Attachment

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Appendices

Appendix A - Summary of OIG Survey Results
Appendix B - Comparison of MMACS Applications
Appendix C - HCFA Response dated April 3, 1986

[COMMITTEE STAFF NOTE: Appendix C, HCFA's April 3, 1986 response to the OIG's February 12, 1986 draft report, is located earlier in this chronology of documents, as is the draft OIG report to HCFA.]

EXECUTIVE SUMMARY

This audit report summarizes our review of the Health Care Financing Administration's (HCFA's) use of the Medicare/Medicaid Automated Certification System (MMACS) to monitor State surveys and certifications of long-term care facilities participating in Medicare and Medicaid. These programs spend over $14 billion annually to provide services to about 1.75 million patients residing in long-term care facilities. As the Federal manager of both programs, HCFA is responsible for ensuring that these facilities are safe and provide high quality care. MMACS was established to assist HCFA fulfill this responsibility by providing a centralized data bank containing a wide array of survey and certification information gleaned from survey reports, corrective action plans and other related documents.

We believe that a centralized data bank such as MMACS is needed to enable HCFA to develop national strategies to monitor the activities of States which are responsible for surveying and certifying long-term care facilities that participate in Medicare/Medicaid.

Our review in eight regions, however, has shown that MMACS was not a fully effective management tool because data on about 19 percent of the long-term care facilities on MMACS was outdated and, therefore, inaccurate. As a result, MMACS could not be effectively utilized by HCFA central and regional managers to plan and develop national and regional strategies, respectively, aimed at protecting the health and safety of Medicare and Medicaid patients in the nation's nearly 20,000 nursing homes.

We are recommending that HCFA get MMACS current, keep it current and use it to plan national strategies for such things as identifying States not in compliance with annual survey requirements; identifying nursing homes with substandard characteristics; and meeting the challenges arising from the Omnibus Reconciliation Act of 1980.

By memorandum dated April 3, 1986, HCFA responded to a draft of this report. While not agreeing entirely with our conclusions and recommendations, HCFA stated that the report contained a number of useful findings that will be included in its overall effort to improve MMACS.

MMACS - DESIGNED TO BE AN EFFECTIVE MANAGEMENT TOOL

HCFA's mission is to promote the timely delivery of appropriate, quality health care to its beneficiaries -- about 50 million of the nation's aged, disabled and poor. In carrying out this mission, HCFA is responsible for ensuring that medical facilities participating in Medicare and Medicaid meet established standards. Facilities must be structurally safe, provide for a sanitary environment, be well staffed and provide high quality care. Annual surveys, certifications and provider agreements are required to ensure that facilities meet these high standards. Medicare and Medicaid pay over $90 million a year for certification related activities to help safeguard the health and safety of patients.

MMACS was designed to play a key role in HCFA's monitoring of State survey and certification activities. Implemented during the early 1970's in response to an ever increasing demand for a centralized data source, MMACS is an automated data retention system that provides information on the quality, quantity, and availability of health care related services in the United States. The data is entered into the system through a dispersed remote data entry tele-transmission network located in the 10 HCFA regional offices.

The information stored in MMACS is essentially a by-product of the State agency conducted Medicare/Medicaid certification process which covers about 42,000 medical facilities of which about 19,180 are long-term care facilities. The data included is derived from completed survey reports, provider applications, plans of correction and other related certification documents. According to a brochure published by HCFA, the data available on the certification process is virtually unlimited and the extent of its usefulness is controlled by the ingenuity and resourcefulness of MMACS users.

MMACS, like any computerized system, is only as good as the information stored in it. In this regard, HCFA is required to evaluate the system every three years. The 1982 evaluation stated that the original requirements and objectives of this network were still valid and were being satisfied efficiently. HCFA recommended continued operation of the system. In its latest evaluation dated March 13, 1985, HCFA's conclusions and recommendations were identical to those stated three years previously.

SCOPE OF AUDIT

Our review was made in accordance with standards for governmental auditing. Our primary objective was to determine if MMACS was an effective management tool for monitoring the certification of long-term care facilities participating in the Medicare and Medicaid programs. In making this determination, we extracted data from MMACS identifying long-term care facilities not surveyed during the 15 month period ended January 1, 1985. To verify the accuracy of this data, we visited 8 HCFA regional offices and reviewed survey reports submitted by 14 States. Lastly, we extracted similar data from MMACS as of October 25, 1985, and May 26, 1986 to determine whether any significant changes had occurred.

MMACS WAS NOT FULLY EFFECTIVE

Our surveys in eight HCFA regional offices showed that MMACS was not a fully effective management tool for use in monitoring surveys and certifications of long-term care facilities. Results of facility surveys, which are required to be performed annually, were not input into MMACS timely; thus, the system's output was out of date and, therefore, not as useful as it should have been. HCFA regional officials perceived this to be a major deficiency within the system and did not fully utilize MMACS.

MMACS Showed Thousands Of Long-Term Care Facilities As Not Being Surveyed Within 15 Months

Prior to passage of the Omnibus Budget Reconciliation Act (OBRA) of 1981, the Social Security Act required States to have provider agreements with long-term care facilities participating in Medicare and Medicaid that generally did not exceed 12 months. Department regulations implementing the provisions of the Social Security Act required annual surveys as a precondition for annual certifications, which in turn were a precondition for annual provider agreements.

The statutory requirement for annual surveys, certifications and agreements was eliminated by Section 2153 of OBRA. The effect of this change was to allow the Department the flexibility to either continue with the regulatory requirement for annual surveys, certifications and agreements or change the regulations as deemed necessary.

HCFA reacted to OBRA by establishing a flexible survey cycle and by publishing a Notice of Proposed Rule Making (NPRM) dated May 27, 1982, removing the annual survey, certification and provider agreement requirements in favor of a flexible cycle. Apparently in reaction to the NPRM, Congress enacted two provisions -- Section 135, Tax Equity and Fiscal Responsibility Act of 1982, (Public Law 97-248) and Section 146, Continuing Resolution Appropriations for FY 1983, (Public Law 97-276) -- that prohibited the Department from issuing a final rule changing the regulations. Establishing a moratorium provided the opportunity for further review, revision or withdrawal of the proposed regulations.

In January 1983, HCFA directed its regional offices to reinstitute the annual survey requirement and to "move toward stricter compliance with all the regulatory provisions..." According to this instruction "a liberal phase-in period would be expected under the circumstances". This direction signaled HCFA's intent to not change the regulatory requirement for a mandated annual cycle. This is evidenced by the fact that although the Congressional moratoria expired on August 28, 1983, HCFA had not issued a final ruling on its NPRM.

Thus, when we began our review in January 1985, two years had passed since HCFA reiterated its intent to require annual surveys. Even giving a "liberal phase-in period" as mentioned in HCFA correspondence, surveys should have been conducted and entered onto MMACS during this interval. We found, however, that as of January 1, 1985, there were 3,849 long-term care facilities out of a total of about 19,180, that, according to MMACS, were not surveyed within the last 15 months (we used 15 months rather than the 12 month regulatory requirement primarily to account for time to enter survey results onto MMACS). This extremely high number of unsurveyed facilities indicated that either there was non-compliance with Federal regulations occurring at the State level, or MMACS contained outdated and inaccurate data.

To determine the actual situation with regard to both MMACS and State survey and certification activities, we visited eight HCFA regional offices and found the general perception of MMACS to be that it was outdated, inaccurate, and could not be fully relied on as an effective management tool. Some of the views expressed were as follows:

... Regional officials recognized that MMACS data was often unreliable and out of date and that the system's usefulness as a management tool was limited.

... MMACS was not fully utilized as a management tool to monitor State survey functions because the information in it did not represent current survey and certification information on all facilities. This region primarily relied on a manual system for monitoring States.

... MMACS was used to backup a manual system that was more current and more responsive to management needs.

We also reviewed survey reports submitted by 14 States for 1,568 facilities identified by MMACS as not being surveyed within the last 15 months. These States accounted for 66 percent of the facilities identified by MMACS as being out of compliance with Federal regulations. We found the regional perceptions to be basically an accurate reflection of MMACS. Data was not current and therefore, not a reliable indication that the survey process was breaking down and in need of review and improvement. We noted that, contrary to what was recorded on MMACS for the 1,568 facilities, 1,506 (96 percent) had been surveyed within the last 15 months but the results had not been entered onto MMACS. As shown in Appendix A, outdated data in MMACS was common in each of the eight regions reviewed.

Projecting the results of our survey to the 3,849 long-term care facilities identified by MMACS as not being surveyed within the last 15 months, we estimated that 3,695 of them, or 19.2 percent of the total number entered onto MMACS, had been surveyed but that the results had not been entered onto the system.

To determine why the MMACS data base was not current, we reviewed the processing of survey results using three key milestone dates obtained from MMACS: the date the survey was completed, the date survey results were received in HCFA, and the date results were entered onto MMACS. Our statistical sample of 230 surveys showed that between 15 and 583 days were needed to complete processing of survey results. The average was 107 days and consisted of:

... 73 days needed by State survey agencies to forward results to HCFA.

... 34 days needed by HCFA to enter the results onto MMACS upon receipt from State survey agencies.

According to the State Operations Manual, States are required to forward survey results of all Medicare and Medicare/Medicaid facilities to HCFA within 45 days after the survey exit interview with the facility. There were 80 such surveys in our sample. We found that for 56 (70 percent) of these surveys, State agencies failed to comply with the 45 day requirement.

The remaining 150 surveys in our sample were for Medicaid-only facilities. State agencies are not required to submit results of surveys of these facilities within 45 days because HCFA does not have to approve their certification. We found that for 105 (70 percent) of these surveys, the State agencies took longer than 45 days to submit the results to HCFA.

Our sample showed that improvements were needed in both the State and Federal segment of the processing cycle if MMACS was to become the effective management tool it was designed to be. States should be required to comply with the 45 day timeframe for Medicare and Medicare/Medicaid facilities. States should also be required to submit survey results on Medicaid-only facilities within the same timeframe. Although HCFA does not have the responsibility to approve certifications for Medicaid-only facilities, HCFA is responsible to ensure that those facilities are properly surveyed and are providing adequate care to Medicaid recipients. The sooner survey results are available to HCFA, the better it can carry out this responsibility.

At the Federal level, HCFA required 34 days to input survey results onto MMACS upon receipt from State agencies. We believe this was unreasonably long.

HCFA Recognized Need To Monitor Survey Activities But Review Methods Could be Improved

HCFA recognized the need for surveillance of State survey and certification activities. In July 1985, HCFA informed its regional offices that during fiscal year 1986 each region had to perform a review in one State to ensure that annual surveys of long-term care facilities were being carried out by State survey agencies. In September 1985, the regional offices were provided with a review guide entitled "Financial Management Review Guide for Provider Agreements (PA) with Long-Term Care (LTC) Facilities".

The review guide instructed regional officials to identify the universe of long-term care facilities furnishing Medicaid services and test the facilities to ensure that annual surveys had been performed and that the facilities had been found in compliance with all Federal requirements. The review guide instructed the regions that beginning October 1, 1985, appropriate disallowance action should be initiated for facilities which did not have a valid provider agreement.

One problem with this one-State-per-region approach was that it provided no sense of urgency to the regions for upgrading MMACS. The review guide, for example, did not instruct the regions to use MMACS to select the single State for review. In fact, the guide's main reference to the system was the simple statement that "most regions have" MMACS. Considering that MMACS was established to provide a centralized data base to facilitate selections of this nature and contained all of the information needed by HCFA to identify every facility in Medicare/Medicaid that potentially did not have a valid provider agreement, HCFA should have emphasized its use.

Our biggest concern with this review method, however, was that it precluded HCFA from planning a national, rather than regional, strategy to identify all uncertified long-term care facilities. If a national strategy were adopted, HCFA could use MMACS to first identify States that had the highest number or percentage of facilities that had not been surveyed according to the latest information. These States would then be selected for review regardless of what HCFA region they were located in. This could very well mean that some regions would be required to review two or more States while in other regions, one State might suffice.

A national strategy such as this, based on an effective MMACS would enable HCFA to precisely pinpoint problem States and facilities, establish review priorities and then act to ensure that surveys were conducted and the health and safety of patients protected. By adopting a regional strategy, HCFA had no assurance that States with the highest incidence of noncompliance would be selected for review.

We compared the 10 States selected for review by HCFA regional offices to the 10 States with the largest number of long-term care facilities not surveyed within 15 months according to MMACS as of October 25, 1985. We found the following:

States With Largest Number of Facilities Not Surveyed Per MMACS		States Selected For HCFA Review	
State	Facilities Not Surveyed	State	Facilities Not Surveyed
New York	640	New York	640
Indiana	269	Michigan	222
Massachusetts	258	California	202
Texas	258	Oregon	106
Pennsylvania	240	Louisiana	77
Michigan	222	Maryland	41
California	202	Maine	30
New Jersey	200	Colorado	20
Ohio	195	Nebraska	17
Illinois	165	Georgia	9

As could be anticipated, adoption of a regional, rather than national, strategy resulted in States with large numbers of long-term care facilities potentially out of compliance with Federal regulations not being included in the planned review. As shown above, 7 of the 10 States with the largest number of facilities not surveyed were excluded while States such as Colorado, Nebraska and Georgia with relatively few unsurveyed facilities were included in the planned review.

We also noted that some regions, particularly Regions I, IV and VII, appeared to have selected States where the incidence of noncompliance with the annual survey requirement was low compared to other States within the same regions.

		MMACS	
Region	States Selected for Review	Facilities Out of Compliance	State Ranking in Region
I	Maine	30	4 of 6
II	New York	640	1 of 2
III	Maryland	41	3 of 6
IV	Georgia	9	4 of 8
V	Michigan	222	2 of 6
VI	Louisiana	77	2 of 5
VII	Nebraska	17	4 of 4
VIII	Colorado	20	1 of 6
IX	California	202	1 of 4
X	Oregon	106	1 of 4

Region 1 was a good example. According to MMACS, Maine had 30 facilities not surveyed within a 15 month period as of October 25, 1985. This compared to Massachusetts with 258 facilities out of compliance; Connecticut with 138 facilities out of compliance and where we knew from our survey that problems did exist at the State level; and Rhode Island with 110 facilities out of compliance.

Unlike our initial MMACS application of January 1985, we did not review survey files to verify the accuracy of MMACS data. Therefore, we did not know, nor did HCFA top management know, whether the 3,842 facilities (Appendix B) shown on MMACS as of October 25, 1985, as not being surveyed within the last 15 months were surveyed but the results not recorded onto MMACS; or whether the States selected by regions for review were the most appropriate selections. We could surmise this, however, either several of the States selected for review were not the most appropriate -- in terms of the number of facilities not inspected -- or that the MMACS information was outdated and not used by HCFA regional staff.

Conclusions and Recommendations

HCFA's contention that MMACS was required to fill an increasing need for a centralized data base is even more valid today than it was at the time MMACS was established. A centralized data base containing such a wide array of survey and certification information should be an ideal foundation on which HCFA could plan national strategies for monitoring States and long-term care facilities and for ensuring the health and safety of 1.75 million Medicare/Medicaid patients in these facilities.

Such strategies could include identification of all long-term care facilities that have not been surveyed within regulatory timeframes. HCFA could then use its limited staff resources to home in on those States with the greatest problems; to require immediate surveys to protect the health and safety of Medicare and Medicaid patients, and to impose fiscal disallowances as a deterrent against repeated occurrences.

Other, more imaginative uses could be made of MMACS to help HCFA meet challenges arising from authorities granted by the Omnibus Reconciliation Act of 1980. This Act authorized

HCFA to take direct action against long-term care facilities based on its own surveys. The Act also authorized HCFA to impose an intermediate fiscal sanction -- denying reimbursements for new admissions for a period of up to 11 months -- against facilities no longer meeting one of more of the conditions or standards for program participation (see ACN 03-60155 for more information on the intermediate sanction).

We therefore, recommend that HCFA:

1. Require regions to enter onto MMACS all available survey information so that the data is as current as possible.
2. Take steps to ensure that the MMACS data base is kept as current as possible. These steps should include:
   a. Enforcing the 45 day timeframe for States to submit survey results of Medicare and Medicare/Medicaid facilities to regional offices.
   b. Establishing and enforcing a timeframe for States to submit survey results of Medicaid-only facilities to regional offices.
   c. Establishing and enforcing a more stringent timeframe for HCFA regional offices to input survey results onto MMACS after receipt from State agencies.
3. Use MMACS as the primary management tool for developing national strategies for monitoring State survey and certification activities; identifying chronically substandard nursing homes for possible enforcement action; and for meeting the challenges of the Omnibus Reconciliation Act of 1980.

HCFA's Response and OIG Comments

In its response to our draft report (Appendix C), HCFA agreed that MMACS should be kept current and accurate and that the report contained a number of useful findings which will be incorporated into HCFA's continuous efforts to improve the accuracy and timeliness of the data.

One of the efforts to improve MMACS is the expansion to 12 States of a pilot project designed to test the feasibility of transferring the responsibility for data entry from the

HCFA regional offices to the States. If all goes as expected, within two years all States should be entering the survey results directly onto MMACS. HCFA's ultimate goal is to have a "paperless process" in which surveyors will use hand-held computers to collect information about a facility, its patients and its compliance and then transmit the data telephonically to the States and HCFA regional offices.

In commenting on the different sections of this report, HCFA, however, disagreed that MMACS was not being used as an effective management tool for monitoring State survey and certification activities; suggested that we overstated delays in entering survey results onto MMACS; disagreed that States selected for review were not appropriate; and disagreed that the one-State-per-region review approach was inadequate.

We have reviewed HCFA's response to our draft audit report and have made some changes to this report as a result. We believe the improvements described by HCFA should upgrade MMACS and that once HCFA's ultimate goal of a "paperless process" is achieved, keeping MMACS current will no longer be a problem. What will remain a key issue, however, is how HCFA will use MMACS in planning and developing management strategy involving the health and safety of 1.75 million Medicare/Medicaid patients in nearly 20,000 long-term care facilities.

HCFA did not specifically respond to our recommendations in the draft audit report to use MMACS for developing national strategies to long-term care facilities and to implement inspection and intermediate sanction authorities granted by the Omnibus Reconciliation Act of 1980. There were clear indications, however, that HCFA top managers intend to use MMACS more as a management tool for evaluating performances of regional offices than for developing strategies designed to ensure that nursing homes are providing adequate care to patients. While an effective MMACS could and should be used as an evaluation device, it should also be used as a national planning device, particularly when there is evidence (see our audit report ACN: 03-60155 for more information on this subject) to suggest that conditions found in hundreds of long-term care facilities throughout the country fail to meet Federal health or safety standards.

HCFA's specific comments along with our response to them follows in the same order as presented by HCFA.

> HCFA did not agree with our conclusion that MMACS was not being used as an effective management tool for monitoring State survey and certification activities. HCFA cited its continual efforts to improve the accuracy and timeliness of MMACS data, its use of MMACS as an evaluation device and its use by regional offices -- although HCFA did admit to some backlog and slow acceptance by some regions.

We agree that recent system enhancements such as the Survey and Certification Operations Report and the Adverse Action Extract will enable HCFA top managers to better utilize MMACS, particularly after the data bank is updated to contain the most current information available. HCFA should be commended for these improvements and for its continued efforts to improve the accuracy and timeliness of MMACS.

We do not agree, however, that these efforts are evidence that MMACS was being used as an effective management tool. To the contrary, the improvement efforts demonstrate, in our opinion, that HCFA managers recognized operational deficiencies and were attempting to correct them so that MMACS could become the effective management tool it was designed to be. In this regard, we noted that HCFA's efforts have begun to produce results. As of May 26, 1986, there were 2,009 long-term care facilities that, according to MMACS, had not been surveyed within the last 15 months. This represents a reduction of about 48 percent over the October 1985 total. A commendable achievement to be sure, but more needs to be done to bring the 2,009 facilities into current status.

As far as MMACS other uses are concerned, they were, at the time of our audit, of limited value because the information contained in MMACS was often outdated. Our report demonstrates that several regions did not use MMACS to select their State for review; nor were they required to use MMACS by HCFA headquarters for this purpose.

> HCFA cited an example showing that because of the timing of surveys, results would not always be entered onto MMACS within a 15 month period. HCFA used this example to indicate that we may have misinterpreted some MMACS data.

We do not believe that we misinterpreted MMACS data. The 15 month timeframe, in our opinion, is ample time to enter annual survey results onto MMACS if the surveys are conducted in accordance with HCFA instructions and the results forwarded to HCFA in a timely manner. Certainly the example cited by HCFA could occur but as an exception rather than the rule.

Unlike HCFA's example where one survey was done in September and the other in November, the majority of surveys are conducted within 30 days of the date of the previous study. In fact, a study made by the Institute of Medicine[1/] under contract with HCFA, reported that some States routinely schedule visits during the same week each year. If, in the case of HCFA's example, the 30 day survey routine and the 45 day processing timeframe were adhered to, the current survey would have been conducted in October and the results forwarded to the HCFA regional office long before the Christmas holidays became a factor.

> HCFA stated that there is no requirement that State agencies forward survey results of Medicaid-only facilities to HCFA regional offices within 45 days since HCFA approval of the certification is not required. HCFA indicated that this is a legitimate reason for MMACS identifying so many nursing homes as not being surveyed within 15 months.

HCFA is correct when it stated that States are not required to submit survey results of Medicaid-only facilities within a 45 day timeframe. While HCFA does not have the responsibility to approve certification of Medicaid-only facilities, HCFA does have the responsibility to ensure that these facilities are properly surveyed and are providing adequate care to Medicaid recipients. If MMACS is to assist HCFA in carrying out this responsibility, it must contain the most current data for the 3,300 Medicaid-only facilities. We believe that the 45 day requirement should be extended to these facilities and enforced.

[1/] Institute of Medicine, National Academy of Sciences. Improving the Quality of Care in Nursing Homes: Report of a Study by the Committee on Nursing Home Regulation, Institute of Medicine. February 1986

> HCFA cited its own study as being similar to our sample and used it to show that processing time was not as lengthy as we had reported.

We do not agree that the HCFA study was "similar" to our sample. Our statistical sample of 230 surveys showed that on the average, 107 days were required to enter survey results onto MMACS after completion of the survey. HCFA's study showed that on the average, 71.89 days were required to approve certification -- either by HCFA or a State agency -- after completion of the survey.

In other words, HCFA's study ended before the survey results were entered onto MMACS. HCFA explained this by stating that since October 1985, the majority of recertifications were entered onto MMACS on the same day as the regional office approved them. While this may be true, HCFA's study covered calendar year 1985, not just the last quarter of the year. Thus, we believe the HCFA study did not cover the entire processing cycle and its results cannot be compared to the results of our sample.

> HCFA disagreed with the "OIG's contention" that the regional offices selected inappropriate States in some cases.

HCFA is referring to the table on page 8 of this report. We pointed out that based on MMACS data, certain regions appeared to have selected States where noncompliance was low compared to other States in the same region. We made it clear, however, that neither we nor HCFA top management knew whether the States selected for review were the most appropriate selections or whether the MMACS data was outdated. It appears evident, however, that if the selections were appropriate, and by this we mean that States with potentially the largest number or percentage of unsurveyed facilities were selected for review, then MMACS data was out of date and virtually useless in the selection process.

> HCFA believed the one-State-per-region approach was adequate citing that it had historically deferred to the regional offices in the selection process. HCFA also mentioned staff availability, travel funding and competing review priorities as other considerations. As an example, HCFA cited that even if reliable MMACS data indicated that every State in Region V required a provider agreement review, HCFA would be unable to conduct these reviews.

Historical deference to the regions, staff availability, travel funds, etc. may be real considerations, but, to be effective, management should be sufficiently flexible to direct limited resources quickly to resolving known problems. Using HCFA's example to illustrate our point, if reliable MMACS data indicated that every State in Region V required a provider agreement review, then these reviews should be made. To do otherwise, would subject Medicare and Medicaid patients in long-term care facilities to unnecessary risks arising from the facilities not being surveyed. An effective MMACS can identify problem areas as well as areas where the risk of problems is low. Priorities can then be established to utilize regional office staff to home-in on high risk areas.

Appendix A

Summary of OIG Survey Results

		Facilities			
Region	States	Out of Compliance Per MMACS	Total Reviewed	MMACS Incorrect	Out of Compliance
I	Massachusetts	244	232	232	
	Connecticut	77	77	60	17
II	New York	439	439	439	
	New Jersey	205	205	205	
III	Pennsylvania	107	70	67	3
IV	Florida	56	56	56	
	South Carolina	41	41	41	
V	Illinois	184	62	55	7
	Michigan	250	55	55	
	Ohio	216	60	57	3
VI	Texas	335	24	24	
	Arkansas	151	24	24	
IX	California	141	141	141	
X	Oregon	82	82	50	32
		2528	1568	1506	62

Appendix B
Page 1 of 2

Comparison of MMACS Applications

	Number of Facilities Out of Compliance (Per MMACS) in January 1985	Number of Facilities Out of Compliance (Per MMACS) in October 1985	Difference
Region I			
Connecticut	77	138	61
Maine	45	30	-15
Massachusetts	244	258	14
New Hampshire	29	7	-22
Rhode Island	26	110	84
Vermont	19	10	-9
Region II			
New York	439	640	201
New Jersey	205	200	-5
Region III			
Delaware	3	12	9
Washington, DC	4	11	7
Maryland	27	41	14
Pennsylvania	107	240	133
Virginia	24	45	21
West Virginia	25	6	-19
Region IV			
Alabama	15	3	-12
Florida	56	36	-20
Georgia	33	9	-24
Kentucky	22	22	-
Mississippi	8	12	4
North Carolina	12	7	-5
South Carolina	41	5	-36
Tennessee	28	4	-24
Region V			
Illinois	184	165	-19
Indiana	297	269	-28
Michigan	250	222	-28
Minnesota	113	112	- 1
Ohio	216	195	-21
Wisconsin	102	48	-54

	Number of Facilities Out of Compliance (Per MMACS) in January 1985	Number of Facilities Out of Compliance (Per MMACS) in October 1985	Difference
Region VI			
Arkansas	151	52	-99
Louisiana	37	77	40
New Mexico	26	18	- 8
Oklahoma	40	38	- 2
Texas	335	258	-77
Region VII			
Iowa	61	33	-28
Kansas	53	24	-29
Missouri	102	54	-48
Nebraska	22	17	- 5
Region VIII			
Colorado	25	20	- 5
Montana	10	10	-
North Dakota	5	7	2
South Dakota	19	3	-16
Utah	5	1	- 4
Wyoming	2	2	-
Region IX			
Arizona	1	3	2
California	141	202	61
Hawaii	7	11	4
Nevada	7	5	- 2
Region X			
Alaska	4	3	- 1
Idaho	15	13	- 2
Oregon	82	106	24
Washington	48	28	-20
	3,849	3,842	

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

6325 Security Boulevard
Baltimore, MD 21207

AUG 27 1986

Copy shared with NCCNHR member groups, long-term care ombudsman programs, and endorsers of the Quality Care Campaign. Mailed with HCFA's "Consumer Evaluation form"

Ms. Elma Holder
Executive Director
National Citizens Coalition
for Nursing Home Reform
1424 16th Street, N.W.
Washington, D.C. 20036

Dear Ms. Holder:

With the implementation of the new long-term care survey process now at hand, we are very much interested in the responses to the questionnaires you sent to the State Licensure and Certification Directors. We applaud your efforts to support this new process and your desire to set in place the best possible protections for nursing home residents. Our concerns parallel yours.

The responses you receive from the questionnaires naturally will be of interest to us in improving the new long-term care survey process. The pulling together and analysis of this information can be quite an undertaking. Please feel free to call upon us if there is any way we can be of assistance.

Along these same lines, we have developed our own questionnaires for completion by nursing home residents and others who would be able to provide feedback. The questionnaires address key areas of concern and would help us in deciding where to make changes in the survey process. We would appreciate your assistance in circulating them. Please have the responses sent to Mary Blevins Slagle, OSC, DDPA, 2-D-2 Meadows East Building, 6325 Security Boulevard, Baltimore, Maryland 21207. It would be helpful to receive them by November 30. *

We have enclosed an ample supply of the two questionnaires. If you need more, please let us know.

Sincerely yours,

Sharon Harris

Sharon Harris
Acting Director
Office of Survey and Certification
Health Standards and Quality Bureau

Enclosures

Questionnaires/surveys:
1 for residents (yellow)
1 for other consumers

Return completed evaluation to
Health Care Financing Administration.

For use by residents.

by November 30, 1986
Address: Backside

RESIDENT EVALUATION OF THE NEW LONG-TERM CARE SURVEY PROCESS

Name (Optional) ________________________________
Facility (Optional) ________________________________
Address ________________________________
____
____

1. Were you aware that a certification survey tock place in your facility? Yes ____ No ____

2. Was a notice of the survey posted and easily visible? Yes ____ No ____

3. Did the notice state that you and your family could talk with the survey team? Yes ____ No ____

4. Did the surveyors wear name tags? Yes ____ No ____

5. Do you feel you were able to participate in the survey conducted in your facility? Yes ____ No ____

6. Were you interviewed in privacy? Yes ____ No ____

7. Did the surveyors respect your wishes in attempting to conduct interviews (e.g., they did not pursue an interview if you did not wish to participate, they stopped the interview if you began to tire, etc.)
   Yes ____ No ____
   If not, explain: ________________________________
   ____
   ____
   ____
   ____

8. Do you feel the surveyors were courteous and patient while interviewing you? Yes ____ No ____

9. Describe any problems that you experienced while being interviewed.
   ____
   ____
   ____
   ____
   ____

(OVER)

Page 2 - Evaluation for Residents to complete

10. Did the State surveyors meet with representatives of the residents council (if one is operating)? Yes ____ No ____ Don't know ____

11. (Answer if you are a member of the residents council) Did the survey have an effect on problems/concerns the residents council raised during the survey? Yes ____ No ____ Don't know ____

12. Is there anything about the survey that was conducted in your nursing home that concerns you and that you would like changed? ____________

13. Provide any additional comments:

Return by November 30, 1986

Return to: Mary Slagle
Health Care Financing Administration
OSC, DDPA
2-D-2 Meadows East Building
6325 Security Boulevard
Baltimore, Maryland 21207

If possible, send copy to NCCNHR
1424 16th Street, N.W., L-2
Washington, D. C. 20036

* Note from NCCNHR: Please copy to
circulate, as necessary, to generate
a wide consumer response

**

Send responses to:
Mary Slagle
OSC, DDPA, HCFA
2-D-2 Meadows East Building
6325 Security Boulevard
Baltimore, MD
21207

CONSUMER EVALUATION OF THE NEW LONG-TERM CARE SURVEY PROCESS

Name: ______________________________
Organization: ______________________________
Address: ______________________________
____
____

1. Were residents aware that surveys took place in their facilities? Yes ____ No ____
2. Were notices of the surveys posted and easily visible? Yes ____ No ____
3. Did the notices state that residents and families could talk with the survey team? Yes ____ No ____
4. Did the surveyors wear name tags? Yes ____ No ____
5. Do residents feel they were able to participate in the surveys conducted in their facilities? Yes ____ No ____
6. Did survey teams interview resident councils? Yes ____ No ____
7. Did the survey have an effect on problems/concerns raised by the resident council? Yes ____ No ____
8. Were the residents able to provide information to surveyors on their conditions and the care provided to them in their particular nursing homes during interviews? Yes ____ No ____
9. Were residents interviewed in privacy? Yes ____ No ____
10. Did surveyors respect the wishes of residents in attempting to conduct interviews (e.g., they did not pursue an interview if the resident did not wish to participate, they stopped the interview when the resident tired, etc.) Yes ____ No ____
    If not, explain: ______________________________
    ____
    ____
    ____
    ____

**
Note that residents should
complete another form

(Over for page 2)

Page 2 - Survey for Consumers to complete
Residents to use a different form

Return by Nov. 30, 1986

11. Did surveyors exhibit patience in interviewing residents who had difficulty communicating? Yes ____ No ____

12. In general, how well did surveyors interview residents? Describe any problems regarding interviewing experienced by residents.

13. Provide any additional comments.

Send response to :

Mary Slagle
Health Care Financing Adm.
OSC, DDPA
2-D-2 Meadows East Building
6325 Security Boulevard
Baltimore, MD 21207

Copy to: Natl. Citizens' Coalition for Nursing
if at Home Reform
all 1424 16th Street, N.W., L-2
possible Washington, D. C. 20036

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date SEP 5 1986

From William L. Roper, M.D. William L. Roper
Administrator

Subject Institute of Medicine (IoM) Study of Nursing Home Regulation--DECISION

To The Secretary

THRU: US ____________
COS ____________
ES ____________

Purpose

The purpose of this memorandum is to seek your agreement on our approach for changes to Federal Medicare/Medicaid requirements affecting nursing homes. This approach is based on our analysis of the IoM study in accordance with the plan outlined in our memorandum of March 27 (Tab A).

Background

It has been widely acknowledged that Federal nursing home requirements and enforcement mechanisms need to be reformed. Our efforts to make changes in 1980 and 1983 met with strong opposition from both the industry, which feared increased costs, and the beneficiary groups, which feared reduced quality. In order to establish a credible basis for reform, HCFA contracted with the IoM to study nursing home care in relation to our standards and provide impartial recommendations for reform. As we noted in our earlier memorandum, the IoM study focuses heavily on the quality of life in nursing homes and on the fact that Federal oversight must play a strong role in ensuring quality because the Federal government is the major payor for nursing home care.

In our assessment of the IoM study, we concluded that it would be counterproductive to attempt to modify current Federal requirements by adding or deleting specific items. Rather, a fundamental restructuring of Federal nursing home requirements would be necessary for the following reasons:

- Currently, Federal requirements skilled nursing facilities (SNFs) must meet to participate in Medicare and/or Medicaid are different from those intermediate care facilities (ICFs) must meet to participate in Medicaid. Similarly, Federal enforcement requirements State agencies and HCFA must follow are separate for Medicare and Medicaid. Two major IoM recommendations involved

MEDICARE
MEDICAID 20

consolidating the SNF and ICF requirements into a single set of "nursing home" requirements and consolidating enforcement requirements into a single set of Medicare/Medicaid requirements. Once we accepted these recommendations, our approach to revising the existing sets of separate rules necessarily changed.

- All the related recommendations were directed not only toward a new single set of nursing home requirements, but, more importantly, toward a fundamental change in the nature of these requirements. The recommendations shift the focus of Federal standards from process measures to outcome measures. (Examples of process measures include general policies, credentials, organizational structures, and recordkeeping. Examples of outcome measures include absence of new decubiti, proper nutrition, psychosocial care, and good hygiene.) Consequently, we were forced to examine many of the recommendations not as potential new requirements but as fundamental changes in current standards.

- The recommendations in many cases would be impossible to consider or implement as stand-alone items without regard to their impact on other requirements. For example, the IoM's conclusions about the relationship of many process requirements to quality of care led us to streamline and consolidate most current process requirements and focus on specific outcomes in other sections.

- There are additional "trade offs" in terms of costs and burdens if related issues can be tied together. For example, instead of simply adding an additional requirement, we might change one or more current requirements and accomplish the same objective while reducing or at least not adding to the current cost or burden.

Our analysis indicates that the net impact of our proposed changes will result in no additional cost either for the nursing home industry to meet the requirements or for the Federal government to conduct inspections to enforce compliance.

Methodology

In considering changes in our current requirements, we established the following set of principles to govern both our analytic methodology and our objective for the final proposals:

- Federal nursing home requirements should provide a mechanism to assure that: (1) the needs of residents are assessed; (2) a plan of care is developed for each resident; and (3) care and services are provided based on this assessment and plan of care.

- o Nursing homes should have the flexibility to implement plans of care and manage resident services without undue, prescriptive burdens resulting in unnecessary costs as long as key resident care outcomes are achieved.

- o Nursing home residents should be afforded adequate protection and rights and be assured the care and services they need and to which they are entitled under law.

- o Federal enforcement requirements should enable inspectors to determine if residents are receiving appropriate care and services in accordance with their assessments and plans of care in a safe and healthful environment.

The IoM recommendations fall into two major categories: (1) Federal requirements nursing homes must meet to participate in Medicare and/or Medicaid; and (2) the requirements HCFA and/or the States must meet in enforcing these requirements. A summary list of all of the IoM recommendations and our responses is at Tab B. The recommendations and our proposed responses concerning nursing home regulations and enforcement issues are at Tabs C and D, respectively.

Proposed Changes to Nursing Home Requirements (Tab C)

o Regulatory Changes

After studying the IoM recommendations dealing with standards nursing homes must meet to participate in Medicare and Medicaid, we concluded that it is desirable to merge the two sets and that the essence of most recommendations could be achieved by revising the current SNF and ICF requirements. Our approach was to:

- consolidate similar requirements;

- maintain SNF/ICF distinctions only where there is a clear need for a difference based on statute;

- consolidate repetitive requirements with single generic statements;

- eliminate outdated, ineffective process/paper requirements; and

- establish clear outcome requirements wherever possible.

We have attached at Tab C a detailed set of responses relating to the specific recommendations.

Proposed Changes in Enforcement (Tab D)

- Regulatory Changes

  Our approach in dealing with the specific IoM recommendations on enforcement parallel our approach in dealing with the nursing home standards. We concluded that many of the recommendations can be achieved by revising the current Medicare and Medicaid survey and certification requirements. In analyzing the IoM's recommendations, we used our experience in developing our new long-term care survey process as well as comments and position statements from consumer groups and the nursing home industry developed over the last 2-3 years on earlier proposed regulatory changes.

- Procedural Changes

  There are a number of IoM recommendations we have accepted which do not require regulatory changes. They can be implemented by changing HCFA's instructions to regional offices and State survey agencies. There are also other actions, directed toward our internal operations, which can be accomplished without formal issuances. In some cases, we had already initiated actions before the IoM issued its report.

We have attached at Tab D a detailed set of responses relating to the specific recommendations.

Legislative Proposals

A few of the IoM recommendations which we believe should be accepted involve statutory changes. These are noted when the individual recommendations are discussed.

Recommendations Not Accepted

There are also some IoM recommendations which we believe are inappropriate and have rejected. There are a number of reasons for these determinations. Some would involve unreasonable costs when measured against potential benefit to residents; others are impossible to implement; and others may actually result in an adverse impact on residents. These are noted when the individual recommendations are discussed.

Miscellaneous Recommendations (Tab E)

There are a number of general recommendations not covered by the above categories. These include such items as training, conducting studies, and data analysis. We have summarized these and our reaction to them at Tab E.

Summary and Conclusions

We believe the approach we have taken has three major benefits. First, it accommodates most of the IoM recommendations. We expect that the quality of life of nursing home residents will improve as a result of changes in our regulation of nursing homes which focus on outcomes rather than process or paper compliance. Second, it benefits the long-term care industry by reducing the unnecessary burdens and costs associated with many of our current, outdated requirements. It will provide individual facilities flexibility in managing their residents' care within a defined framework of Federal requirements. Third, it will provide a clear, direct statement of Federal expectations for nursing homes, and will reflect a "state of the art" approach.

If you agree with our approach, we will proceed to draft regulations and legislative proposals for your review. I would be pleased to brief you in detail on these issues.

Decision

Develop specific draft regulations and legislative proposals.

Concur: ______________________ Nonconcur:______________________ Date:_________

Attachments:
Tab A - March 27, 1986 Memorandum to the Secretary
Tab B - Summary of IoM Recommendations and HCFA Responses
Tab C - Recommendations on Nursing Home Requirements
Tab D - Recommendations on Enforcement Requirements
Tab E - Recommendations on Miscellaneous Items

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date MAR 2 7 1986

Henry R. Desmarais

From Henry R. Desmarais, M.D.
Acting Administrator

Subject Institute of Medicine Study of Nursing Home Regulation Issues -INFORMATION

To The Secretary

Thru: US ______
Chief of Staff ______
ES ______

BACKGROUND

As a result of Congressional concerns about regulations governing nursing homes under Medicare and Medicaid in 1982, the Health Care Financing Administration (HCFA) entered into a $1.6 million contract with the Institute of Medicine (IoM) to study the full range of nursing home regulatory and enforcement issues and to provide recommendations for changes in the system. The IoM formed a Committee on Nursing Home Regulation consisting of experts in gerontology, consumer advocates, State government officials, and nursing home industry representatives. The committee held hearings, gathered extensive data, consulted with numerous experts and interested parties, and deliberated among themselves over the course of the 3 year study. The report was formally submitted to the Department in late February 1986.

The major theme of the study is the overall quality of life in nursing homes. This is a distinct change from past studies of nursing homes which characteristically have focused on some aspects of poor care or services. Although there are specific criticisms and specific recommendations, these are subsumed within the general context that nursing homes are "homes" as opposed to "institutions," and Federal regulations and enforcement should provide for assuring a broad range of appropriate care and services tailored to the specific needs of residents. The care and services must be directed to both the physical and mental well-being of residents across a broad spectrum of needs, including health care, psychological and social needs.

Another critical aspect of the study is its philosophical assumptions as to the Federal role with respect to nursing homes. The free market philosophy is noted and dismissed on the grounds that the public sector (principally Medicaid) provides most funds for nursing home care, and the history of nursing homes proves that when market forces governed, quality of care was substandard. Consequently, the IoM concludes, Federal regulation and oversight form the foundation of quality care. The entire study is based on this philosophy.

The following is a summary of the major IoM findings and recommendations, and our plans for responding to the study. At Tab A is a history of Federal involvement in nursing home regulations, and a complete listing of IoM recommendations is at Tab B.

The IoM's analysis and recommendations are basically divided into two major areas: regulations and enforcement. Regulations are defined here as Federal requirements nursing homes must meet to receive Federal Medicare and/or Medicaid reimbursement for the cost of care of eligible residents in skilled nursing facilities (SNFs) and intermediate care facilities (ICFs). Currently these requirements consist of "conditions of participation" for SNFs, for which Medicare and Medicaid is available, and "standards" for ICFs, for which only Medicaid is available. The enforcement of the regulations is contained in both regulation and administrative issuances forming the survey (inspection) and certification (approval/disapproval for participation/reimbursement) process.

Currently HCFA contracts with State health departments and pays 100 percent of costs for surveying Medicare SNFs and provides a 50 percent match for the survey of Medicaid SNFs and ICFs. Under current law HCFA certifies for participation in Medicare and States certify for participation in Medicaid, but HCFA has the authority to "look behind" the procedural and substantive correctness of State determinations and take action to terminate participation in Medicaid (e.g., halt Federal share payments), for any facility found to be substandard.

PROBLEMS WITH THE CURRENT REGULATORY REQUIREMENTS AND THE SURVEY/ CERTIFICATION PROCESS

The following are the problems the IoM determined were most significant:

- Although many nursing homes today provide excellent care to their residents, many are substandard.
- The existing regulatory and enforcement system fails to either compel compliance or removal from the system.
- Regulations focus more on the capacity of a facility to provide a set of services than on whether or not the facility's performance actually meets resident needs in safe and healthful environments and fail to consider the quality of life residents experience in nursing homes. Resident choices in important aspects of their daily lives are not mentioned, and assessments of individual functional needs are not required.

- Surveys are too predictable, allowing nursing homes to "dress up" in anticipation of their surveys.

- The survey process is inefficient in that it is applied the same way regardless of whether the facility is historically a "good" provider or a "poor" provider and makes no allowance for the observed diversity among residents and across facilities.

- Studies have shown great variations among States in the way they survey facilities and how they deal with deficiencies.

- Enforcement is more often directed toward helping a facility reach compliance than taking necessary actions if compliance is not achieved. Tolerance for repeated deficiencies remains common.

- Federal level of enforcement activity (look behind survey activity and reviews of State certification actions) is inadequate. Only 3 percent of nursing homes each year receive a Federal look behind survey.

MAJOR RECOMMENDATIONS

The IoM has made extensive recommendations involving regulations and their enforcement, as well as non-HCFA programs such as the national ombudsman program operated by the Administration on Aging, Office of Human Development Services. The major recommendations include:

Federal Regulatory Requirements

- Require all nursing homes to meet a single set of SNF requirements which would be oriented to resident condition and needs. There would be no ICFs; all facilities would meet the higher SNF requirements (especially in terms of nurse staffing), and care for all persons needing long term care services. This would include the full spectrum of nursing home care from those in need of relatively intense skilled nursing care to those who are fairly independent but just below the ability to care for themselves.

- Add new requirements including:

    - Quality of Life - would require residents to be cared for "in such a manner and in such an environment as will promote maintenance or enhancement of their quality of life without abridging the safety and rights of other residents."

    - Quality of Care - would require the facility to provide each resident with care that meets individual physical, mental, and psychosocial needs in order to maintain or improve each resident's physical, mental, and emotional well-being.

- + Resident Assessment - would require the facility to provide each resident with functional assessments upon which the services to be provided under the quality of care requirements will be based.

  + Resident Rights - which would elevate existing rights provisions (plus several new rights provisions) to a condition of participation, meaning that before a facility can participate, the rights of the residents must be assured.

  + Administration - which would consolidate a number of existing facility management provisions into a single condition of participation.

o Emphasize nurse's aide training, including a State approved preservice training program that must be passed before employment.

o Prohibit facilities from having different standards of admission, transfer, discharge, and service for individuals on the basis of sources of payment. Thus nursing homes would no longer be able to accept a private pay resident instead of an eligible Medicaid recipient.

o Allow residents to participate in decisionmaking in the facility, allow ombudsmen to participate in surveys, and expand access to the facility at reasonable hours.

Enforcement Process

o Consolidate Medicare and Medicaid survey and certification rules in one place.

o Base the survey process and protocols on the new conditions of participation, with particular emphasis placed on use of the resident assessment system called for in the new conditions.

o Develop two types of surveys - a "standard" survey for historically good providers, and a more detailed "extensive" survey, using a larger sample of residents, for facilities with compliance problems. Survey periods would vary from 9 - 15 months.

o Survey protocols should also vary as a function of differing resident characteristics (e.g., one survey approach for "heavy care" residents and a different approach for "light care" residents).

o The Federal Government should again assume 100 percent of survey agency costs for at least 3 years.

- HCFA should set minimum surveyor qualifications.
- HCFA should increase Federal look behind activity and enforcement powers (e.g., increase range of sanctions).
- States should survey and certify both Medicare (Title XVIII) and Medicaid (Title XIX) facilities, but HCFA should survey and certify all public facilities.
- HCFA should require States to strengthen enforcement capabilities through increased commitment of resources; employment of attorneys, auditors, and investigators; increased training in investigatory techniques, witness preparation, etc.; and increased Federal training support in enforcement matters.

Resident Advocacy

- The Older Americans Act (administered by the Administration on Aging, Office of Human Development Services) should be amended to provide for the national nursing home ombudsman program under a separate title, and the program should be funded with State/Federal matching formula grants (2/3 Federal, 1/3 State).
- Ombudsmen should be provided access to nursing homes, and with permission of the resident, to a resident's medical and social record.
- The Administration on Aging should provide more effective national leadership of the ombudsman program with staff resources dedicated to the administration of the program.
- HCFA should require State long term care regulatory agencies to develop working relationships with State ombudsman programs covering information sharing, training, and case referral.

PLANS FOR RESPONDING TO THE STUDY

Internal Action

- HCFA staff have begun analyzing the study's findings and recommendations and implications.
- Some recommendations are appropriate and noncontroversial; others are difficult public policy issues. Most require statutory and regulatory changes and many have major cost implications.
- Over the next 3 months, staff will develop specific proposals relative to each of the recommendations that will detail:
  - options associated with the recommendation; including cost implications and potential outside reaction;

- the HCFA recommendation on the policy issues raised; and
- the specific plans and approach necessary to adopt the recommendations.

External Relations

We anticipate consumer advocacy and Congressional pressure to obtain clear and timely commitments from the Department as to how we will respond to the study's recommendations. Our posture, reflecting our commitment to appropriate action, should be general receptiveness to the study and a commitment to a thorough review. We believe this timeframe is appropriate given the time it took for the study (3 years) and the scope, complexity, and sheer size (450 pages) of the report.

I would be happy to brief you in detail on the study and our plans at any time.

Attachments

TAB A

History of Federal Regulation of Nursing Homes

- As early as 1950, the Social Security Act required States to establish programs for licensing nursing homes, but did not specify what the standards or enforcement procedures should be.

- The passage of the Medicare and Medicaid Acts in 1965 provided the Department of Health, Education and Welfare with new authority to set standards for "extended" care facilities (ECF) under Medicare and skilled nursing facilities (SNF) under Medicaid.

- Disasters of various sorts in nursing homes increased the pressure for effective regulations in the early 1970s. The ICF benefit was transferred to the Title XIX program in 1971, and the ICF/MR benefit was added at the same time.

- In 1971, President Nixon committed the Federal government to a program of improvements in nursing homes, and in 1972, the Congress provided full funding for State survey and certification activities. Also, the ECF benefit was merged into the SNF program as one benefit.

- Congress directed that DHEW produce a single set of SNF requirements for Medicare and Medicaid in 1972, but final regulations were not promulgated until 1974. Final ICF and ICF/MR standards were published in 1974 as well.

- In 1975, the State of Colorado and the Department were sued in Federal Court in Colorado on behalf of an individual, alleging that authorities were not enforcing nursing home requirements, and seeking the Court's power to force the enforcement of regulations (Smith v. O'Halloran, later known as Smith v. Heckler).

- As early as 1976, efforts were underway to revise the SNF conditions of participation, but it was not until 1980 that HCFA proposed a significant revision of nursing home regulations that contained the following major provisions:

  - SNF and ICF requirements were merged into one set of conditions of participation;

  - the proposal included a "Patient Care Management System" designed to be used as a standard means of assessing resident care needs; and

  - elevated the patient rights standard to the "condition of participation" level.

- The proposals were viewed as too expensive to implement by the nursing home industry, but they were supported widely by nursing home advocates. Former Secretary Harris promulgated only the patients' rights section in final form at the close of the Carter administration, but the rule was rescinded on the first day of the Reagan administration.

- The Smith v. Heckler case was put on hold pending the adoption of the proposed rules. However, when the rule never became final, the case was tried in 1982.

- In 1981 and early 1982, HCFA attempted to revise the SNF conditions in keeping with the Reagan administration's regulatory reform initiative. Draft changes were leaked to the press and ensuing controversy resulted in halting all work on nursing home facility requirement revisions.

- HCFA published proposed changes in survey and certification rules in May 1982 (the so-called Subpart S revisions). Proposed changes included:

  - Medicare and Medicaid survey and certification rules were combined in one place;

  - Flexible survey cycles were proposed to focus on problem providers;

  - JCAH would be provided with "deemed status" for long term care facilities, meaning that accredited facilities would be "deemed" as meeting Medicare/Medicaid requirements for certification.

- Opposition to these proposals, particularly the JCAH deemed status proposal, resulted in a Congressional moratorium imposed on HCFA to prevent any regulatory changes in long term care and survey/certification regulations (ICF/MR regulations were excluded from the moratorium).

- In 1982 HCFA contracted with the Institute on Medicine (IoM) to conduct a full scale study of nursing home regulations, the survey and certification process, and attendant enforcement issues.

- As a result of the wide divergence in survey findings among the States, and in recognition that there would be no new regulations in the near term, HCFA began developing a new long term care survey system, called Patient Care and Services (PaCS). The first draft was completed in 1983. Extensive field testing, consultation with outside groups, and formal evaluation by Brown University resulted in a final version that was completed in 1985.

IOM Report on Nursing Home Regulation

Following is a summarized listing of recommendations contained in this report.

Regulations

1. There should be one level of care; there will be no ICFs.
2. The SNF requirements will apply.
3. The Conditions of Participation should be changed. The following conditions should be added:
    a. Quality of life
    b. Quality of care
    c. Resident assessment (standardized assessment tool for all facilities)
    d. Resident rights
    e. Administration
4. The following should be under Administration:
    a. Standard on nurse aide training (pre-service).
    b. Standard on nondiscrimination by source of payment.
    c. Standard enabling ombudsmen to examine records with resident permission.
    d. Standard allowing ombudsmen access to the facility at reasonable hours.

Survey Process

1. Medicare/Medicaid certification process requirements should be combined in the CFR.
2. Surveys should be timed between 9 and 15 months (TLAs out).
3. Surveys should be two-staged.
    a. A standard survey equaling key indicators but can trigger an extended survey.
    b. An extended survey equaling process surveys plus paper surveys.
4. Standard surveys should be:
    a. Stratified random sampling based on case mix.
    b. Resident-based.

5. The complaint process should be specified.

6. The ombudsman should be part of the process by participating in the survey and the exit conference.

7. Superior performance should be commended.

8. The survey process should be revised in concert with new conditions of participation listed in Chapter 3.

9. The process should be tested to ensure reliable, consistent results.

10. A sample of facilities should receive the extended survey every year.

11. State agencies should be required to implement the process based on effective training and monitoring of surveyor performance to reduce inconsistency.

12. States should be refunded to 100 percent under Title 19 for survey and a standard formula for funds should be devised in proportion to certification workload.

13. Guidelines should be revised for the following:

    a. Surveyor qualifications.
    b. Team composition.
    c. Team size.
    d. Nurse participation.
    e. Participation of other specialists.

14. Information on all survey demonstrations and experiments should be routinely disseminated to all States.

15. Training activities should be increased during the transition to the new survey process.

16. Oversight activities by regions should be increased.

    a. There should be more Federal surveyors.

    b. There should be more valid look-behind surveys.

17. The Federal government should be able to withhold Title 19 funds from States that do not perform well.

18. IoC should be come part of the survey, but should be done only from a sample of patients.

19. Utilization Review activities should be focused on a sample of patients who are most likely to be discharged.

20. States should certify all Medicare/Medicaid facilities. HCFA should monitor this activity more actively. HCFA should survey and certify State facilities.

Enforcement

1. Surveyors should not be consultants.

2. Surveyors should be given criteria on how to evaluate plans of correction and judge their acceptability.

3. Guidelines should be given to States on the performance of onsite followup surveys and circumstances when enforcement action should take place.

4. States should have formal enforcement procedures and mechanisms. These include terminations, sanctions, fines, etc.

5. Title 19 should be amended in the following ways:

   a. States should have specified intermediate sanctions such as admissions bans, fines, receivership, transfer.

   b. HCFA should be allowed to write procedures to impose more severe restrictions. Consider previous record and obtain assurances prior to recertification.

   c. The appeals process should be less permissive.

6. HCFA should strengthen State's activities in the following ways:

   a. Specify minimum resources needed.

   b. Require staff to include lawyers, auditors and investigators.

   c. Provide training for surveyors in the legal system and as witnesses.

   d. Provide training support for State agency attorneys.

Community Involvement

1. HCFA should require States to make public survey and facility cost reports.

- A Court of Appeals ruled in the summer of 1985 in the Smith v. Heckler case that the Secretary did have the duty, and not just the authority, to enforce Federal nursing home requirements and remanded the case back to the District Court for a determination of how the Department would ensure that it would enforce its rules.

- HCFA then proposed a plan to the Court that implementation of the PaCS process would address the shortcomings in the system that prompted the case in the first place.

- The District Court agreed with the plan, but required the Secretary to publish a regulation by October 31, 1985 stating how the plan would result in the Department enforcing its nursing home rules. HCFA complied and published a proposed rule describing the new PaCS methodology and directing States to adhere to Federal survey and certification procedures in the Medicare and Medicaid programs.

- HCFA intends to implement PaCS as soon as the regulation is published in final form later this spring.

2. Amend the Older Americans Act.
    a. authorize the ombudsman program as a separate title;
    b. authorize Federal-State matching formula for the ombudsman program;
    c. authorize access to nursing homes and to resident's records (with the resident's permission) by certified substate and local ombudsmen;
    d. authorize State legal assistance for ombudsmen; and
    e. .exempt ombudsmen from lobbying restrictions in OMB Circular A-122.

3. The Secretary should direct AoA to get effective leadership.

4. HCFA should require written agreements by the State agencies and ombudsman.

5. Accreditation programs are positive steps within the industry; however, deemed status should not be granted to any group.

Future Study

1. An information system on all residents should be put in place.

2. A standard resident assessment methodology should be developed.

3. Medicaid payment policies should continue to be studied.

4. Bed supply and demand should continue to be studied.

Tab B — Summary of IoM Recommendations and HCFA Responses

IoM Recommendation		HCFA Recommended Response (Action Needed)
Nursing Home Requirements - Tab C		
(1)	Implement single set of long term care conditions of participation for skilled nursing (SNF) and intermediate care (ICF) facilities.	ADOPT (Regulation)
	Existing SNF conditions should be revised and made applicable to all nursing homes.	REJECT - Retain some distinctions in combined regulations between SNFs/ICFs.
(2)	Add a new condition of participation concerning "resident assessment."	ADOPT (Regulation)
(3)	New and revised conditions should follow principles outlined.	ADOPT (Regulation)
(4)	Add a new condition of participation concerning "quality of life."	ADOPT (Regulation)
(5)	Add a new condition of participation concerning "quality of care."	ADOPT (Regulation)
(6)	Raise "resident rights" to a condition of participation.	ADOPT (Regulation)
(7)	Consolidate existing administrative standards into a single condition of participation called "Administration."	ADOPT (Regulation)
(7a)	Delete current requirements for institutional planning and quarterly staffing reports.	ADOPT (Regulation)
(7b)	Add a new standard on nurse's aide preservice training.	REJECT preservice training but ADOPT new standard on nurse aide training for employed staff. (Regulation)
(7c)	Add new standard prohibiting different standards of admission, and service for private pay vs. Medicaid recipients.	REJECT - We should have no authority over private business' management of private pay residents.

IoM Recommendation		HCFA Recommended Response (Action Needed)
(7d)	Record and confirm periodically identity of legally responsible persons to be notified of significant events in life of nursing home residents.	ADOPT (Regulation)
(7e)	Add a new standard requiring facility to permit resident participation in life of facility.	ADOPT (Regulation)
(7f)	Add new requirements to permit access of ombudsmen and others to residents during reasonable hours.	ADOPT (Regulation)
(8)	Add requirements for adequate lighting, noise control, and comfortable temperature.	ADOPT (Regulation)
(9)	Require facilities to hire at least one full time social worker for each facility with more than 100 beds.	REJECT - This is a prescriptive/input requirement that is not in keeping with outcome orientation of other requirements.
Enforcement Requirements - Tab D		
(1)	Consolidate Medicare and Medicaid survey and certification rules.	ADOPT (Regulation)
(2)	Create flexible survey cycles (9 - 15 months) to decrease predictability	ADOPT - HCFA recommends 6 - 18 month cycle. (Regulation)
(3)	Develop 2 survey protocols - one for standard surveys and one for extended surveys (increased resident sample size) of problem facilities.	ADOPT (Procedures)
(4)	Surveys should assess samples of residents based on standard case-mix categories.	ADOPT - Dependent upon research and testing before case mix methodologies can be used in practice. (Procedures)

IoM Recommendation		HCFA Recommended Response (Action Needed)
(5)	Standard surveys should rely on "key indicators" of quality of resident life.	ADOPT - Dependent upon continued analysis of data from new Long Term Care Survey Process. (Procedures)
(6)	Facilities performing poorly on "key indicators" should receive extended survey.	ADOPT - Dependent on (4) and (5). (Procedures)
(7)	Surveys should rely heavily on interviews and observations of residents and staff.	ADOPT - Current HCFA practice. (Procedures)
(8)	Specify uniform complaint investigation procedures.	ADOPT (Statute)
(9)	Require facilities to permit residents to participate in survey entrance and exit conferences and require facilities to post notice of survey and invite further resident comments.	ADOPT (Procedures)
(10)	Facilities with demonstrated good performance should be recognized.	ADOPT - But HCFA rejects "official" mechanisms. (Procedures)
(11)	Survey protocols should reflect new conditions of participation and future revisions.	ADOPT (Procedures)
(12)	Survey protocols should be tested before implementation.	ADOPT - Current HCFA practice. (Procedures)
(13)	A random sample of facilities should receive an extended survey each year regardless of compliance history.	REJECT - HCFA direct look behind surveys achieve the purpose of this recommendation.
(14)	HCFA should improve State survey performance, consistency, and reliability through better training.	ADOPT - Ongoing HCFA initiative. (Procedures)

IoM Recommendation		HCFA Recommended Response (Action Needed)
(15)	HCFA should pay 100 percent of State survey agency costs for 3 years.	REJECT - HCFA supports 50-50 cost sharing of survey activity. (Statute)
(16)	HCFA should set qualifications for surveyors, team composition, and team size.	ADOPT - Current HCFA initiative. (Statute)
(17)	Federal surveyor training efforts should be increased.	ADOPT - Current HCFA activity. (Procedures)
(18)	National data about survey operations should be compiled and distributed.	ADOPT - (Procedures)
(19)	HCFA should (a) add Federal surveyors, (b) schedule Federal surveys closer to State surveys, and (c) fix penalties for States that do not follow Federally mandated survey procedures.	(a) REJECT (b) ADOPT (Procedures) (c) ADOPT (Statute)
(20)	Integrate survey and certification with inspection of care process.	ADOPT - Current HCFA initiative. (Statute)
(21)	States should survey and certify both Medicare and Medicaid facilities except HCFA should survey and certify all public facilities.	ADOPT - Except HCFA should not survey public facilities but should only certify public facilities. (Statute)
(22)	HCFA should revise post-survey procedures to make consistent nationally.	ADOPT - (Statute)
(23)	Increase range of options for (a) State Medicaid intermediate sanctions and (b) Federal use of intermediate sanctions.	(a) REJECT - State law provides for ranges of sanctions. (b) ADOPT - Permit HCFA to use intermediate sanction with Federal look behind authority. (Statute)
(24)	Increase authority to sanction chronic or repeat offenders.	ADOPT (Regulation)
(25)	Make Medicaid appeals process more stringent.	ADOPT - conform with Medicare appeals procedures. (Statute)

	IoM Recommendation	HCFA Recommended Response (Action Needed)
(26)	HCFA should strengthen State enforcement capabilities - require States use additional specialized staffs.	ADOPT - Except HCFA believes current resources sufficient. (Procedures)
Miscellaneous Requirements - Tab E		
(1)	Facilities should make public (a) all inspection reports and (b) all cost reports.	(a) ADOPT (Regulation) (b) REJECT - State law governs release of Medicaid reports, and Medicare cost reports are already releasable for a small fee.
(2)	Amend Older Americans Act re: Ombudsman Program.	Administration on Aging (AoA) lead.
(3)	Strengthen AoA leadership	AoA lead.
(4)	State survey agencies should have agreements with State ombudsmen programs.	ADOPT (Procedures)
(5)	Should conduct study on acquiring and using resident assessment and and other data to facilitate regulatory and policy development.	ADOPT - Current HCFA initiative
(6)	HCFA should conduct study of benefits of single vs. multiple occupancy rooms in nursing homes.	REJECT - This is not an issue of Federal regulatory involvement; appropriate private industry study.

Tab C — Nursing Home Requirements

The IoM approached the issue of nursing home care requirements with three fundamental objectives:

- Combine the SNF and ICF requirements and focus on meeting the nursing and other needs of the patient.
- Abandon the primary focus on surveying a facility's capacity to produce quality health care ("process" requirements) and focus on the health care outcomes actually produced.
- Develop better objective measures of quality care so that subjective (and inconsistent) survey findings are minimized.

The recommendations relating to standards and conditions for nursing home participation were laid out in Chapter 3 of the IoM study and are listed at this tab, along with HCFA's proposed responses.

(1) IoM Recommendation

The regulatory distinction between SNFs and ICFs should be abolished. A single set of conditions of participation and standards should be used to certify all nursing homes. The current SNF conditions and standards with the modifications and additions recommended (in the remainder of Chapter 3), should become the bases for new certifying criteria.

Proposed Response

We agree that most conditions of participation should be applicable to both SNFs and ICFs. However, our analysis of the IoM recommendation that existing ICFs should meet all SNF conditions (including those to be added by IoM recommendations and existing conditions in revised form), would mean a significant increase in requirements for current free-standing ICFs. If this were done, there would be no real distinction between SNFs and ICFs, even though the Congressionally intended distinctions between levels of services would remain in the law.

Therefore, we recommend establishing a single set of requirements for nursing homes but retaining certain distinctions between ICFs and SNFs in the regulations. For example, we would not require 24 hour nursing staff coverage in free-standing ICFs, nor would statutory utilization review requirements for SNFs be applicable to ICFs. We would also require patient assessments as the means of determining resident needs and service requirements.

(2) IoM Recommendation

A new condition of participation on resident assessment should be added. It should require that in every certified facility a registered nurse who has received appropriate training for the purpose shall be responsible for seeing that accurate assessments of each resident are done upon admission, periodically, and whenever there is a change in resident status. The results should be recorded and retained in a standard format in the resident's medical record.

Proposed Response

We agree substantially with this recommendation and propose to create a new condition of participation called "Resident Assessment," which would require that the facility make both an initial assessment (to assure immediate attention) and a comprehensive assessment within 2 weeks of admission. The assessment would be re-evaluated and updated every three months and when significant changes occur in the resident's status. We would specify the basic information to be included in the assessment.

We would not specify an RN to be responsible for the assessment for two reasons:

- we do not propose to require RN staff coverage in ICFs, and

- we believe that the facility is best suited to decide whether an individual or a team or which other mechanism should be used to accomplish the assessment so long as residents receive effective functional assessments.

We also would not require a standardized assessment tool because no single assessment tool has yet been recognized as the best or most reliable. Facilities should have the flexibility to decide how they will conduct the required functional assessments.

(3) IoM Recommendation

The existing SNF conditions and standards should be rewritten in accordance with the (following) principles and made applicable to all nursing homes:

a. Address resident needs and the effects of care on them and the performance of the facility in providing care rather than the facility's capability to perform (outcome vs. process).

b. Be based on the best professional standards for providing high quality of care and quality of life to nursing home residents.

c. Be clear and specific so that it can be understood by facilities, applied consistently by trained surveyors, and be legally enforceable.

d. Be internally consistent, logical, and comprehensive.

e. Include physical, mental, and social functioning; nursing care; nutritional status; social services; physician care; psychological care; pharmacy; dental care; environment; residents' rights; emotional well being; personal choice; satisfaction; and community interaction.

f. Be sensitive to each facility's case mix, meaning the variations in the services required and outcome expectations for residents with different needs found in one facility.

g. Not be unnecessarily burdensome on facilities.

Proposed Response

We concur with the principles and would apply them (consistent with our response to Recommendation (1)) to both revisions of existing regulations as well as to proposed new conditions recommended by the IoM.

(4) IoM Recommendation

A new condition of participation concerning quality of life should be added to the certification regulations. The condition should state that residents shall be cared for in such a manner and in such an environment as will promote maintenance or enhancement of their quality of life without abridging the safety and rights of other residents.

Proposed Response

We concur in the recommendation and would create a new condition of participation called "Quality of Life" that would require the facility to ensure that residents receive care in a manner and in an environment that maintains or enhances their quality of life in the areas recommended by the IoM without abridging the safety and rights of other residents.

(5) IoM Recommendation

A new condition of participation on quality of care should be added to the certification regulations. It should state that each resident is to receive high-quality care to meet individual physical, mental, and psychosocial needs. The care should be designed to maintain or improve the residents' physical, mental, and emotional well-being.

Proposed Response

We agree with this recommendation and would propose to add a condition of participation called "Quality of Care." The condition would require that each resident receive the necessary nursing, medical, and psychosocial services to attain and maintain the highest mental and physical functional status as possible, as defined by the comprehensive assessment and plan of care. We would include such standards as: Activities of Daily Living; Vision and Hearing; Drug Therapy; Decubitus Ulcers; Accidents; Nutrition; Urinary Catheters; Dehydration; Contractures; Special Nursing Needs; and Psychosocial Functioning.

Each standard would be stated both in terms of desired positive outcomes and the avoidance of negative outcomes. Enforcement would relate the patient's actual condition to the comprehensive assessment and plan of care.

(6) IoM Recommendation

The existing standard on residents' rights should be made into a condition of participation. The condition should state that every resident has certain civil and personal legal rights that must be honored by the staff of the facility. Rights specified in this condition as they pertain to a resident who has been adjudicated incompetent in accordance with State law, shall devolve to the resident's guardian, or, if required by the State, a responsible party. In cases where the attending physician determines that a legally competent resident is incapable of exercising a right, the conditions and circumstances shall be fully documented in the medical record and shall devolve to a responsible party. The following standards should be added to the rights condition:

a. All residents admitted to the facility shall be told that there are legal rights for their protection during their stay at the facility and that these are described in an accompanying written statement. Reasonable arrangements shall be made for those who speak a language other than English. At such time as the rights set forth in this condition are revised, residents shall be given the updated information. Further explanation of the written statement of rights shall be available to residents and their visitors upon reasonable request to the administrator or designated staff person.

b. Each resident has the right to know the name, address, and phone number of the State survey office, State or local nursing home ombudsman office, and State or local legal service office. The facility shall post such information in a location accessible to residents and visitors.

c. Each resident has a right to see written facility policies. Facilities make policies available on request. Facilities shall post State survey reports and plans of correction in a location accessible to residents.

d. Each resident may inspect his/her medical and social records upon request to the facility. The resident may request and receive copies of the records at a photocopying cost not exceeding the amount customarily charged in the facility's community for similar services.

e. Each resident must receive prior notice of transfer, discharge, and lapse of bed-hold periods. The facility must notify the resident, resident's representative, and attending physician in writing

(1) at least 3 days prior to the lapse of bed-hold periods,
(2) at least 3 days prior to intrafacility transfers,
(3) at least 4 days prior to discharge from the facility except as specified in documented emergencies.

The notice must contain the reason for the proposed transfer, the effective date, the location to which the facility proposes to transfer the resident, a statement that the resident may contest the proposed action, and the address and telephone number of the State or local nursing home ombudsman.

f. Each resident, along with his/her family has the right to organize, maintain and participate in resident advisory and family councils. Each facility shall provide assistance and space for meetings. Council meetings shall be afforded privacy, with staff or visitors attending only upon the council's invitation. A staff person shall be designated responsible for providing this assistance and for responding to written requests that result from council meetings. Resident and family councils shall be encouraged to make recommendations regarding facility policies.

g. Each resident has the right to meet with visitors and participate in social, religious, and political activities at their discretion so long as the activities do not infringe on the rights of other residents. This includes the right to join others within and outside the facility to work for improvement in long-term care. The facility must permit each resident to receive visitors and persons or groups on the resident's own initiative. Visitors must be granted access to residents. The residents, however, have the right to refuse or terminate any visit.

Proposed Response

We concur in this recommendation. We recommend that a residents' rights condition of participation should state unambiguously that each resident has a right to a dignified existence, self-determination, communication with and appropriate access to persons and services inside and outside the facility and that the facility must assert, protect, and facilitate the exercise of these rights. We propose that the standards in this section state clearly what the residents' rights are.

(7) IoM Recommendation

A new condition of participation entitled "Administration" should be established. The following current conditions of participation should be reclassified as standards under this new condition: governing body and management, utilization review, transfer agreements, disaster preparedness, medical direction, laboratory and radiological services, and medical records.

Proposed Response

We concur with this recommendation, and in keeping with our overall effort to reduce burdensome, prescriptive, and duplicative requirements, we would further propose to revise the existing conditions to make them more outcome oriented and to provide facilities with greater flexibility in how they perform these administrative functions.

(7a) IoM Recommendation

The current requirements for institutional planning and submission of quarterly staffing reports should be eliminated in drafting the new administration condition.

Proposed Response

We propose to eliminate these requirements.

(7b) IoM Recommendation

A new standard, nurse's aide training, should be added to the administration condition. The standard should require that all nurse's aides complete a preservice State approved training program in a State accredited institution such as a community college.

Proposed Response

We propose to reject this recommendation. While we support preservice training programs, we recognize that few preservice State approved training programs exist, and if we required facilities to hire only aides who have successfully completed this type of training, the available employment pool would be drained and an artificial shortage of aides would be created. As a compromise, we will encourage States and the private sector to continue to develop preservice training programs. At the regulatory level, we plan to evaluate aides by their actual ability to perform necessary duties. We believe that the pressure to provide adequate aide services will stimulate both States and provider groups to better training programs.

(7c) A new standard should be written under the administration condition of participation that prohibits facilities that have signed a Medicaid provider agreement from having different standards of admission, transfer, discharge, and service for individuals on the basis of sources of payment.

Proposed Response

We propose to reject this recommendation. To the extent that explicit conditions of participation are not spelled out in the law, we are empowered only to impose regulatory requirements relating to health and safety. Our conditions of participation are applicable to all of a facility's patients; however, we do not believe it is appropriate to expand our mandate to include establishing rules which relate to the manner in which a facility conducts its business affairs. Five states have enacted laws prohibiting discrimination on the basis of source of payment, though no analyses have been conducted to determine the effectiveness of these laws. To the extent that States believe it is appropriate to impose requirements such as those in this recommendation, we believe they may do so under State law.

(7d) When the governing body and management condition is rewritten and incorporated in the new administration condition, the current standard "j" (Notification of changes in patient status) should be changed to require the facility to record at admission and periodically confirm or update the identity of a guardian, conservator, or resident's representative to be notified in the event of (1) care conferences; (2) changes in the resident's physical, mental, or emotional status; (3) an accident involving the resident; (4) change in billing; (5) change of room; (6) discharge from the facility; or (7) changes in Federal or State residents' rights. Notification should be timely.

Proposed Response

We agree with the recommendation.

(7e) A new standard should be added to the Administration condition that would require every facility to develop and implement a plan for regular resident participation in decision-making in the facility's operations and policies and for presentation of resident concerns. Forms of resident participation can include, but are not limited to, resident councils, regularly scheduled resident forums, resident issue or program committees, and grievance committees. Facilities should include existing resident councils and/or other resident representatives in developing this plan.

Proposed Response

We concur in this recommendation.

(7f) Two new elements should be added to the governing body and management standard as follows:

a. Certified nursing homes should be required to permit access to the homes by an ombudsman (whether volunteer or paid) who has been certified by the State. With permission of a resident or legal guardian, a certified ombudsman should be allowed to examine the resident's records maintained by the nursing home.

b. Any authorized employee or agent of a public agency, or any authorized representative of a community legal services organization, or any authorized member of a nonprofit community support agency that provides health or social services to nursing home residents should be permitted access at reasonable hours to any individual resident of any nursing home.

Proposed Response

We concur with this recommendation.

(8) Standard 5, "Other Environmental Considerations" in the Physical Environment condition currently reads ". . . provision is made for adequate and comfortable lighting levels in all areas, limitation of sounds at comfort levels, maintaining a comfortable room temperature ... ." It should be amended to add, at this point, "that is within acceptable ranges of operative temperature and humidity for persons clothed in typical summer or winter clothing for light, mainly sedentary activities, as specified in the ANSI-ASHRAE Standard 55-1981." This is the standard prescribed by the nationally recognized American National Standards Institute. Waivers may be granted for existing facilities until such time as substantial renovation takes place.

Proposed Response

We concur in this recommendation, especially since the IoM recognizes the need for waivers for facilities for which retrofitting costs would be prohibitive.

(9) The present social services condition should be changed to require that each facility with 100 beds or more be required to employ at least one full-time social worker. Qualifications for this position should be a bachelor's degree in social work, a master's degree in social work, or some equivalent degree in an applied human services field at the bachelor's level or higher as approved by the State. Facilities with fewer than 100 beds or those in rural areas that have made a good-faith effort and have been unable to recruit a qualified social worker with the required credentials may substitute a contractural arrangement with a community agency or with an independent social work consultant. However, the HCFA should establish a minimum level of effort for social services in exempted facilities-for example, one day of consultation per week.

Proposed Response

We propose to reject this recommendation. Since we are implementing an outcome oriented survey process, we believe that new regulations should be outcome, rather than process oriented. Thus, we propose to require facilities to ensure that the social services needs of residents identified through comprehensive functional assessments are met. We would leave to the facility how they would meet them.

Tab D -- Enforcement Requirements

Chapter 4 of the IoM's report dwells on the need to make changes in the mechanics of the survey process as well as to revise the delegation of survey responsibilities to avoid current problems at the State level. Its recommendations relate to the consolidation of the survey process, an increase in Federal activities and oversight, and an underlying change in the government's approach to the process to emphasize enforcement rather than assistance. Coordination of HCFA's efforts with other Federal programs is also recommended.

Chapter 5 of the IoM's report continues with recommendations for altering sanctions for poor performance in such ways as to increase the range of penalties available in order to suit the purpose of compelling compliance rather than termination. Recommendations also attempt to deal with the health and welfare of patients in facilities which have not complied with Federal requirements.

The recommendations from these two chapters and HCFA's proposed responses follow.

(1) IoM Recommendation

Medicare and Medicaid survey and certification process requirements should be consolidated in one place in the Code of Federal Regulations to promote consistency.

Proposed Response

We concur in this recommendation and would propose a new set of certification rules applicable to both the Medicare and Medicaid programs.

(2) IoM Recommendation

The timing of surveys should maximize the element of surprise; the standard annual survey should be conducted somewhere between 9 and 15 months after the previous annual survey, with the average across all facilities within each State remaining at 12 months. Additional standard surveys also should take place whenever there are key events, such as a change in ownership. Independent of the survey cycle, all facilities should be required to pass rigorous life safety code and food inspections at regular intervals.

Proposed Response

We endorse this recommendation. We would propose a 6 to 18 month survey cycle. Facilities with poor compliance histories would be surveyed between 6 and 9 months, and facilities with good compliance histories would be surveyed between 15 and 18 months. This increases the unpredictability range, and rewards the better performing facility. Of course, more frequent, follow-up visits can be made as needed.

(3) IoM Recommendation

Two new survey protocols should be designed and tested to implement the new conditions and standards recommended in Chapter 3: a standard survey and an extended survey. Both must be based on the revised conditions of participation and standards.

Proposed Response

We concur with this recommendation. We believe that the implementation of the new long term care survey process (often referred to as the Patient Care and Services (PaCS) process) this Summer will effectively achieve the objectives of this recommendation in the context of current regulations. The new survey process is client centered and outcome oriented, depending upon the assessment of the care provided to a sample of residents. While we do not have data to establish criteria for deciding when a facility should receive an extended, rather than a standard survey, we can expand the survey sample of residents to make it as large as we need to make a full and accurate assessment of the care provided residents. When we implement the recommendations relating to revised conditions of participation, we will tailor our long term care survey process to the new conditions.

(4) IoM Recommendation

Both standard and extended surveys should assess samples of residents stratified by standard case-mix categories. Case-mix definitions, and the procedures and sample sizes required to attain a prespecified level of precision, should be established by the HCFA.

Proposed Response

We concur with this recommendation, yet the data base necessary for the full implementation of a case-mix methodology for use in surveys is still years away. Research in case-mix methodology is on-going in a number of States, and HCFA is financing research, as well.

We have contracted with Brown University's Long-Term Care Gerontology Center to perform two separate studies that will impact on the methodology for selecting a sample of residents during the survey process.

As resident assessment data accumulates and the case-mix methodology is tested and refined, we would propose to adopt the tools for use in helping us do a better job in performing surveys. We believe also that the development of resident centered, outcome oriented conditions of participation (as outlined in Chapter 3) as well as the new long term care survey process will facilitate greatly the integration of a case-mix methodology once it is fully available.

(5) IoM Recommendation

The standard survey should rely on "key indicators" of quality of resident life and care that would be prescribed by the HCFA. These key indicators would measure poor resident outcomes and other resident and facility conditions that might be caused by noncompliance with the Federal conditions and standards and should be investigated further by the survey agency.

(6) IoM Recommendation

Facilities that perform poorly on key indicators of quality of resident care or life should be subjected to a full or partial extended survey, depending on the range of problem areas discovered. The purpose of the extended survey is to determine the extent to which the facility is responsible for the poor outcomes due to noncompliance with the Federal conditions and standards.

Proposed Response

We support these two closely related recommendations, and would propose they be adopted fully when we implement new conditions of participation for SNFs and ICFs. We believe HCFA's new long term care survey process already emphasizes review of many of the key indicators suggested by the IoM report (e.g., dehydration, contractures, decubitus ulcers, unexplained weight changes), in addition to its more process-oriented features such as the drug review and the dining and eating assistance observation. We also intend to develop national and regional norms for each key indicator, controlled for case-mix, that can be used in making compliance decisions when this type of data becomes available. However, we believe that the current state of knowledge makes it inappropriate to limit the standard survey process only to the review of key indicators.

The PaCS survey also requires the routine examination of a number of areas that would not be included in the IoM report's standard survey protocol (e.g., review of drug administration, dietary programs, meal presentation, eating assistance, nursing staff levels). We intend to conduct testing with an abbreviated version of the PaCS survey which would closely resemble the key indicator standard survey envisioned by the IoM. The eventual national implementation of such a screening survey, with triggering to a more process oriented survey based on key indicators established by HCFA will depend on: (1) the results of the testing and (2) the availability of case-mix data and performance norms for key indicators on a national basis.

(7) IoM Recommendation

Quality assessment in the survey process should rely heavily on interviews with, and observation of, residents and staff, and only secondarily on "paper compliance," such as chart reviews, official policies and procedures manuals, and other indirect measures of actual care given and resident outcomes.

Proposed Response

We agree with the IoM's assertion that the residents themselves should be the focus of attention and that the quality of resident care is best determined by direct observation and contact between the surveyor and the resident and the surveyor and the caregiver. The new long-term care survey process was predicated on this belief.

(8) IoM Recommendation

The HCFA should require States to have a specific procedure and sufficient staff to properly investigate complaints.

Proposed Response

We agree with this recommendation and would propose to amend Section 1902(a) of the Social Security Act to require that the Medicaid State Plan require the State survey agency to abide by any complaint procedures and reporting requirements as may be established by the Secretary. Besides establishing uniformity among the States, it would eliminate existing differences between Medicare and Medicaid complaint investigation requirements and procedures.

(9) IoM Recommendation

The HCFA should incorporate in its survey operations manual the following additional procedures to be followed by surveyors in addition to interviews with those residents sampled for the survey protocols:

- At the beginning of the survey, surveyors should meet briefly with members of the facility's resident council or with a group of willing and capable residents to elicit general information about services and resident satisfaction as well as to identify any areas of particular concern.
- Resident representatives should participate in the part of the exit conference where deficiencies are cited and the plan of correction is discussed.
- At the close of the survey, the following notice should be posted in a location accessible to residents and visitors:

> "The (State survey agency) completed its regular certification survey of (facility name) on (date) . Anyone wishing to provide additional information may contact the (State survey agency) before (date) .
>
> (address)
>
> (phone) "

Proposed Response

We concur with this recommendation and would propose to implement it quickly simply by changing our instructions to the States; no statutory or regulatory changes would be needed.

(10) IoM Recommendation

In addition to exempting good facilities from extended surveys, ways should be explored to commend superior performance.

Proposed Response

We agree that we should train surveyors better to emphasize the positive aspects of surveys, and we agree in principle that facilities should be commended for good performance, but we do not support formal, government sanctioned programs of public recognition. The quality of care in a facility can change rapidly, or incidents can occur that would contrast sharply with a government commendation, leading to criticism. We believe that the efficacy of the PaCS survey process is such that continued participation in HCFA programs should ultimately be a key indicator of the facility's quality of care.

(11) IoM Recommendation

The new survey protocols, including the forms, procedures, and guidelines used by surveyors, should be designed in accordance with the revised and amended conditions and standards recommended in Chapter 3, and they should be revised as the conditions and standards are changed in the future.

Proposed Response

It logically follows that if the conditions of participation are changed, survey protocols and possible procedures should be changed.

(12) IoM Recommendation

All survey protocols (instruments and procedures) should be tested so that they are capable of yielding reliable and consistent results when used by properly trained surveyors anywhere.

Proposed Response

It has always been our policy to require testing and evaluation of experimental survey protocols. For example, the new long term care survey process underwent repeated testing prior to its implementation and will continue to be evaluated and further refined as data is assessed based on national use. The consistency with which surveyors apply the survey protocol has been and will continue to be an integral element of all evaluation designs.

(13) IoM Recommendation

A sample of facilities should be subject to an extended survey each year. Information from this sample should be used to validate and improve the standard survey.

Proposed Response

We propose to reject this recommendation. Assuming that other IoM recommendations concerning variable survey cycles and the development of key indicators which would trigger more extensive and frequent reviews are adopted and implemented, survey agencies and HCFA will have ample data to provide information on how to improve the standard survey. The further imposition of a required sample of extended surveys will only add to the cost of surveys and the workload of surveyors without an appreciable contribution to our knowledge about how to improve the survey process.

(14) IoM Recommendation

The HCFA should require the State agencies to implement a program to develop and support consistent and reliable surveys. This program should be based on effective training and monitoring of surveyor performance to reduce inconsistency.

Proposed Response

We concur in this recommendation, but believe that our current, ongoing training effort, especially as it relates to our new long term care survey process, is responsive to this concern.

(15) IoM Recommendation

Title XIX of the Social Security Act should be amended to authorize 100 percent Federal funding of costs of the nursing home survey and certification activities of the States. This authority should be extended for 3 years, after which time a Federal-State matching ratio should be reestablished. The HCFA should develop a standard formula for distributing funds to the States under this authority so that each State is funded on an equal basis in proportion to its Federal certification workload.

Proposed Response

We propose to reject this recommendation. The Federal government paid 100 percent of survey costs during the early years of development of effective State survey and certification systems (1972 - 1980). The purposes of the original full funding schedule have long since been realized - each State has a fully operational and effective survey and certification program. Reducing the Federal share is the best way to ensure the efficient and effective use of both Federal and State survey funds through sharing of costs on an equal basis. We have already submitted a legislative proposal to accomplish this change. There is an issue of efficiency,however, and HCFA is administratively improving the method by which it allocates its Medicare survey funds to the States, which will improve the efficiency with which States use their survey funds.

(16) IoM Recommendation

The HCFA should revise its guidelines to make them more specific about the qualifications of surveyors and the composition and numbers of survey team staff necessary to conduct adequate resident-centered, outcome-oriented inspections of nursing homes. At a minimum, every survey team should include at least one nurse. For use on extended surveys, the survey agency should have specialists on staff (or, in small States, as consultants) in the disciplinary areas covered by the conditions and standards (for example, pharmacy, nutrition, social services, and activities).

Proposed Response

We propose to accept this recommendation in part. We agree that we need to ensure that States have sufficient, qualified staff to perform satisfactory surveys; however, we believe that the States are best able to determine their own staffing needs. We would favor a statutory change allowing HCFA to require specific team compositions and qualifications in those States HCFA finds are not performing their survey responsibilities properly.

(17) IoM Recommendation

Federal training efforts and support of State-level training programs should be increased, especially during the period of transition to the new survey process, and during the implementation of the new resident assessment condition of participation.

Proposed Response

We concur with the recommendation in principle. We believe that the Federal role in surveyor training and in support of State level training programs is important and vital, but we disagree that the effort needs to be increased in quantity through increased staff and appropriations, and we plan to continue with improvements that can be made within existing budget contraints. During FY'86, for example, we will have trained over 550 surveyors in our basic training course. HCFA staff routinely serve as instructors in training courses and as consultants to State surveyor training programs. We have developed innovative training programs that involve computer assisted instructional modules that have been distributed nationally. We have experimented with teleconferencing as a means of increasing participation in training at significantly lower costs. In summary, HCFA currently aggressively engages in training activities and supports the States in their own training efforts as well.

(18) IoM Recommendation

National data about survey operations and results, and from any experiments and demonstrations sponsored by the HCFA or the States, should be collected, analyzed, and disseminated by the Federal government to facilitate continued improvement in survey methods.

Proposed Response

We agree with this recommendation, but believe that our current efforts to gather and disseminate information are satisfactory. We routinely collect and analyze survey data and disseminate aggregate survey results to the HCFA regional offices and from there to the States. We have also provided the States with summaries of the evaluation findings from the testing of the new survey process. The collection and analysis of survey results will be one of our primary means of assessing the effectiveness of the new survey process. We will make every effort to keep the States and interested public informed of both survey results and our evaluation of the new survey process.

(19) IoM Recommendation

The HCFA should increase its capabilities to oversee State survey and certification of nursing homes and to enforce Federal requirements on States as well as facilities by:

- adding enough additional Federal surveyors to each regional office to ensure that the random sample of nursing homes surveyed each year in each State is large enough to allow reasonable inferences about the adequacy of the State's survey and certification activities;
- scheduling "look behind" surveys so that valid comparisons can be made of the findings of Federal and State surveys; and
- amending Title XIX of the Social Security Act to authorize the HCFA to withhold a portion of Medicaid matching funds from States that perform inadequately in their survey and certification of nursing homes.

Proposed Response

We agree with the recommended results but propose to reject the recommendation concerning hiring more Federal surveyors. Assuming that other recommendations concerning administrative improvements in how Federal staff resources are allocated are adopted, we believe current staff levels in the regional offices are sufficient to carry out the recommendations for improved Federal oversight of the SNF/ICF enforcement process. Improvements in the process itself (e.g., implementation of the new long term care survey process), coupled with improvements in State survey and certification efforts will increase the overall effectiveness of the oversight function. We schedule Federal surveys more closely to State surveys through management changes; no regulatory changes are needed.

We concur with the third recommendation and would propose that we amend the Social Security Act to authorize withholding of FFP if the Secretary determines that: (a) a State plan does not conform to State plan requirements, or (b) the State survey agency, under contract with the State Medicaid agency, is not adhering to regulatory or statutory State plan requirements. FFP may be withheld in an amount of not more than 10 percent of the State's total FFP the first year, following the Secretary's determination that the State is not following survey and certification procedures, and not more than 20 percent the following year if compliance still has not been achieved. If compliance has not been achieved by the State after two years, the Secretary will halt all payments. This proposal would provide an intermediate sanction that could be used in lieu of disallowing all matching funds to a State.

(20) IoM Recommendation

The inspection-of-care function should be carried out as part of the new resident-centered, outcome-oriented survey process. But individual resident reviews should be required for a sample of residents (private-pay as well as Medicaid) rather than for all residents (although individual States may elect to continue 100 percent reviews.

Proposed Response

We concur with the recommendation and would propose statutory changes to accomplish it.

(21) IoM Recommendation

The respective roles and responsibilities of the Federal and State governments should be realigned as follows:

- The States should be responsible for certifying all Medicare and Medicaid facilities (except State institutions) according to Federal requirements.
- The HCFA should monitor State performance more actively and be responsible for conducting surveys of, and certifying, State-owned institutions directly.

Proposed Response

We agree with the recommendation that the States assume certifying authority in the Medicare program as well as the Medicaid program, but we disagree with the recommendation that HCFA should assume survey and certification responsibility for all public facilities. Rather, if Federal surveyors find public facilities that have substantial deficiencies, these facilities must be surveyed by independent professional surveyors approved by the Secretary and the facilities would then have to be certified by HCFA before being allowed to participate in the program: We would propose amending the Social Security Act to effect these changes.

(22) IoM Recommendation

The HCFA should revise its guidelines for the post survey process. Revisions should include:

- specifying that survey agency personnel not be used as consultants to providers with compliance problems;
- specifying how to evaluate plans of correction and what constitutes an acceptable plan of correction;
- specifying the circumstances under which onsite follow-up visits may be waived;

- specifying circumstances under which formal enforcement action should be initiated, and how actions should be taken; and
- requiring that States have formal enforcement procedures and mechanisms.

Proposed Response

We generally concur in these recommendations. The statutory change noted in recommendation (20) would enable us to carry it out.

(23) IoM Recommendation

The Medicaid authority should be amended to authorize a specified set of intermediate sanctions on chronic or repeat violators of certification regulations. The HCFA should develop detailed procedures to be followed by the States to deal with such facilities. Procedures should include, but not be limited to:

- ban on admissions,
- civil fines,
- receivership, and
- emergency authority to close facilities and transfer residents.

Proposed Response

We propose to reject the recommendation for more Federal sanctions. We believe that States are best able to determine how to sanction nursing homes short of termination. As the IoM pointed out, many States already have in place a wide range of sanctions. We propose to adopt the recommendation that the Secretary be allowed to ban admissions resulting from Federal Medicaid look behind surveys

(24) IoM Recommendation

The Medicaid statute should be amended to provide authority to impose sanctions on chronic or repeat violators of certification regulations. The HCFA should develop detailed procedures to be followed by the States to deal with such facilities. Procedures should include, but not be limited to:

- the authority to impose more severe sanction,
- a requirement to consider a provider's previous record before certifying or recertifying, and
- the responsibility to obtain satisfactory assurances prior to recertifying, that the deficiencies that led to a termination will not recur.

Proposed Response

We propose to adopt this recommendation by regulation.

We propose to adopt the recommendation that facilities be made to provide more substantial assurances of compliance before readmission to the program. Minimal waiting periods would be established. These would be regulatory changes.

(25) IoM Recommendation

The Medicaid Statute should be amended to make the appeals process on sanction, particularly decertification, less permissive. The HCFA should issue regulations and guidelines to implement this new authority.

Proposed Response

We propose to adopt the recommendation that the appeals process be made more stringent. This could be accomplished by amending the law to make the appeals procedures for facilities which the Secretary determines do not meet requirements for participation in Medicaid, but do not pose an immediate and serious threat to the health and safety of residents consistent with termination procedures under Medicare (Section 1866). This proposal would establish consistent Federal policies for Medicare and Medicaid. It would also improve the effectiveness of Federal enforcement efforts.

(26) IoM Recommendation

The HCFA should strengthen State enforcement capabilities by:

- requiring States to commit adequate resources to enforcement activities, including legal and other enforcement-related staff;
- requiring survey and certification survey agency staffs to include enforcement-related specialists, such as lawyers, auditors, and investigators, to work as part of special survey teams for problem situations and to help support enforcement decision-making;
- including more training in investigatory techniques, witness preparation, and the legal system in the basic surveyor training course; and
- providing Federal training support for State survey agency and welfare agency attorneys in nursing home enforcement matters.

Proposed Response

We concur with the IoM recommendation in principle, and propose to increase our training efforts in this regard, but we disagree that we need more financial and staff resources to do so. We believe that increased training efforts will address this issue properly. We also believe that States have a responsibility to expend funds and efforts in improving their enforcement activities as well, especially since nursing homes are typically licensed by the State as well as certified for participation in the Medicare and/or Medicaid programs.

Tab E - Miscellaneous Recommendations

Chapters 6 and 7 contain a variety of recommendations relating to areas either not directly connected with HCFA's mission or not related to the regulatory and enforcement activities described in Tabs C and D. These items are noted at this tab, along with HCFA's comments.

(1) IoM Recommendation

The HCFA should require States to make public all nursing home inspection and cost reports. These documents should be required to be readily accessible at nominal cost to consumers and consumer advocates, including State and local ombudsmen.

Proposed Response

We agree. Survey materials are already public documents and States should not make it difficult to obtain them. We would propose regulatory revisions that would require the States to make survey findings readily available to residents and consumer advocates, as well as the public at large.

Costs reports under the Medicare program are already available from HCFA regional offices for a small fee, so no further requirements are necessary. We propose to reject the recommendation that HCFA compel States to release Medicaid cost reports since State law already governs the release of financial information about State expenditures.

(2) IoM Recommendation

The Older Americans Act should be amended to

- establish the ombudsman program under a separate title of the act;
- increase funds for State programs by authorizing Federal-State matching formula grants for State ombudsman programs. The formula should provide each State with a minimum annual budget in the range of $100,000 (1985 dollars) plus an additional amount based on the number of elderly residents in the State. The Federal-State matching ratio should be two-thirds Federal to one-third State funds;
- establish a statutory National Advisory Council composed of State ombudsmen, State and local aging agencies, provider and consumer representatives, State regulators, health care professionals (physicians, nurses, administrators, social workers), and members of the general public to advise on administration, training, program priorities, development, research, and evaluation;
- authorize State-certified substate and local ombudsmen, including trained, unpaid volunteers, access to nursing homes, and, with the permission of the resident, to a resident's medical and social records;
- authorize public legal representation for ombudsman programs;
- exempt the ombudsman programs, including substate ombudsmen who are supported by funds from the State ombudsman program, from the antilobbying provisions of OMB Circular A-122.

(3) IoM Recommendation

The Secretary of HHS should direct the Administration on Aging (AoA) to take steps to provide effective national leadership for the Ombudsman Program. At a minimum the Commissioner of AoA should designate a senior full-time professional and some supporting staff to assume responsibility for administering the program. Priority should be given to establishing a national resource center for the program that would develop, in consultation with State programs, an information clearinghouse, training and other materials to assist States, and guidance to States on data collection and analysis. The center should advise on establishing program priorities, and sponsor research and evaluation studies.

Proposed Response

HCFA has no reponse to these two recommendations since they concern the activities of the Administration on Aging in the Office of Human Development Services.

(4) IoM Recommendation

The HCFA should require State long-term-care regulatory agencies to develop written agreements with State ombudsman programs covering information-sharing, training, and case referral.

Proposed Response

We propose to adopt this recommendation, and have begun preparation of a model letter of agreement. No statutory or regulatory changes would be necessary to implement this recommendation.

(5) IoM Recommendation

The Secretary of HHS should order a study to design a system for acquiring and using resident assessment data to meet the legitimate and continuing needs of State and Federal government agencies. The Secretary also should order a study to determine the needs for other data about nursing homes that would facilitate regulation and policy development. This study should recommend specific ways to collect, analyze, and publish or otherwise make such data publicly available.

Proposed Response

HCFA is already involved in studying many of the issues detailed in this recommendation. For example, HCFA's Office of Research and Demonstration (ORD) has contracted with Brown University to conduct a longitudinal study of case-mix outcomes and resource use in nursing homes. ORD is also organizing a 5-State, 5-year study to examine whether assessment data obtained through a case-mix reimbursement system can be used to monitor individual resident care and the overall quality of care of individual nursing homes. In the context of the Tab C and D changes we agree are necessary, these studies are adequate to meet the program needs. We do not feel that it would be cost-effective to commission any additional studies at this time relating to system design or additional data needs.

(6) IoM Recommendation

The HCFA should commission a study of the costs and benefits of single-occupancy rooms compared to multiple-occupancy rooms in nursing homes. The study should be designed to obtain data about the effects of single rooms on the quality of life of various types of nursing home residents. The study should be completed within 2 years after it has been authorized. It should contain recommendations for the desired proportions of single- and multiple-occupancy rooms in nursing homes. It should recommend required proportions in future new construction and major remodeling of existing buildings.

Proposed Response

We propose to reject this recommendation. We believe that any study of this issue would reveal that some would prefer private rooms and some would prefer roommates. The mix of private and multiple occupancy rooms is not a proper Federal determination. Market forces (including the level of Federal subsidy) and local needs should dictate this mix. It would be more appropriate for the private nursing home industry to undertake.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

6325 Security Boulevard
Baltimore, MD 21207

SEP 12 1986

This letter sent to addressees on attached list.

Ms. Evvie Munley
Legislative Analyst
American Association of Homes for the Aging
1129 20th Street, N.W.
Suite 400
Washington, D.C. 20036

Dear Ms. Munley:

We recently completed revised procedures and guidelines related to the new long term care survey process. In order to get as much feedback as possible on the new process, we are forwarding the following documents for your review and comment:

1. Draft procedural guidelines for the SNF/ICF survey process section of the State Operations Manual (SOM).
   - includes a recommended survey team model
2. Draft care guidelines for the Appendix of the SOM.
3. [*] Report on comprehensive study of survey team composition.
4. [*] Brown University report on long-term care survey evaluation.

When finalized, items 1 and 2 above will replace the SNF/ICF survey procedures that are currently in the SOM.

Comments are being requested from groups that represent a variety of perspectives, including practitioners, providers, consumers, and surveyors. Most of the instructions contained in the procedural and care guidelines were developed with the benefit of public comments, so we do not expect extensive comments. We note, however, that the instructions for selection of the resident sample for in-depth review have been revised in connection with information provided in the Brown report. We have also given direction for ascertaining when further development for adverse action (other then immediate and serious threat) is warranted.

We are particularly interested in your comments on the resident sampling procedures. If you have ideas for modifications to these procedures, we encourage you to submit them along with suggested language for the instructions.

In order to avoid delays in publishing the SOM issuance, we have enclosed both the procedural and care guidelines even though the care guidelines are in rough draft form. If we learn that major problems do exist, we will hold a meeting with representatives from all interested groups.

MEDICARE
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[*] [NOTE: These documents are omitted from the record for brevity.]

Please forward your comments and suggestions to me at 6325 Security Blvd., Room 2-D-2 Meadows East Building, Baltimore, Maryland 21207 by October 31.

Sincerely yours,

Sharon Harris
Acting Director
Office of Survey and Certification
Health Standards and Quality Bureau

Enclosures

Skilled Nursing Facility and Intermediate Care Facility (SNF/ICF) Process

OVERVIEW

Use this survey process for all surveys of SNFs and ICFs. (This process is not to be used for ICF/MR or Swing Bed Hospital Surveys.)

A complete LTC facility survey essentially consists of three components--Life Safety Code requirements; administrative and procedural requirements (Part A of the SRF) and direct resident care requirements (Part B of the SRF).

A. Life Safety Code (LSC) Survey--The LSC surveyor applies the particular edition of the Code applicable to each facility, either in conjunction with or separate from the activities of the other surveyors. (See SOM 2470 et al.)

B. Part A of the SNF/ICF Survey Process--This supplements Sections 2700-2736, as appropriate. Use form HCFA-525 for this portion, which consists of a review of the organizational and procedural requirements from all of the applicable Conditions/Standards. Part A includes the following types of requirements for both SNFs and ICFs:

- written administrative and resident care policies
- bylaw and other documents that govern the organization of the facility

- o written agreements with outside resources
- o staff qualifications and written staff development programs
- o committee meetings and reports
- o disaster preparedness and other written plans

C. Part B of the SNF/ICF Survey Process--Use form HCFA-519 for this portion, which includes the requirements from all of the applicable Conditions/Standards/Elements that are directly related to resident care. It focuses on the actual provision of care and services, as well as resident outcomes. Part B includes dietetic services requirements, for example, that address the actual preparation and frequency of meals. The facility's written policy governing meal hours, on the other hand, is not reviewed in this portion of the survey because this type of requirement--written resident care policy--is covered in Part A.

USE OF PART A--INITIAL SURVEYS ONLY

Use Part A of the SNF/ICF Survey Report (form HCFA-525) for initial surveys only. A HCFA determination of compliance, based on documented examination of the written policies and procedures and other pertinent documents during the initial survey, will establish the facility's compliance status with Part A requirements until otherwise demonstrated.

A. Effect of Part A on Resurveys of Participating Facilities--Part A will not be used for resurveys of participating SNFs and ICFs. Those facilities will be determined to meet the administrative and procedural requirements based on their history of compliance (initial survey). This does not preclude citing deficiencies pertaining to administrative and procedural requirements when uncovered incidental to a Part B survey. To assure continued compliance with the administrative and procedural requirements, however, each facility, at the time of recertification, must complete an affidavit attesting that no substantive changes have occurred that would affect compliance. The affidavit language is included on the form HCFA-1516, Request for Certification in the Medicare and/or Medicaid program. Each facility must also agree to notify the State agency (SA) immediately of any changes in its organization or management which may affect its compliance status.

In those instances where the SA receives information that there have been substantial changes in a facility's organization and management:

- Do not initiate a new Part A survey, but review the identified change to ensure compliance with regulations. That is, review the changes in written policies, procedures, licensure, personnel qualifications, agreements, committee structure, etc. Request copies, if they weren't submitted.

- o Determine, through the Part B survey, whether the changes have had an adverse effect and resulted in deficiencies.
- o If deficiencies are found:
  - cite them on the form HCFA-2567; and
  - if justified, apply the appropriate sanctions based on the Part B findings.

If no deficiencies result, yet the facility did not report the change(s), annotate the change(s), and remind the facility to report in the future.

USE OF PART B

Use Part B of the Survey Report (form HCFA-519) for all types of SNF and ICF surveys--initial, recertification, follow-up, complaints, etc. Thus, each SNF and ICF will receive a Part B survey no less often than annually.

A. Complaints--A full Part B survey need not be performed for every complaint. The nature of the complaint will dictate the scope of the survey/investigation. If the complaint alleges substandard care in a general fashion, perform a full Part B survey. If the complaint is of a more specific nature, such as an allegation of improper medications, perform an appropriate partial Part B survey. In this case, the drug pass and a review of selected medical records would likely be appropriate.

B. Re-Survey-Follow-up Visit--Let the nature of the deficiencies dictate the scope of the follow-up visit. Use appropriate sections of Part B to follow-up on the cited deficiencies and plan of correction. A complete Part B re-survey will be needed in rare instances. If the deficiencies are so widespread that a full Part B survey is needed, a question would arise as to the effectiveness of the prior survey.

C. The Seven Survey Tasks in the Part B process are:

Task 1. Entrance Conference
Task 2. In-depth, Integrated Tour and Selection of Resident Sample
    Section A - Resident Needs
    Section B - Physical Environment
    Section C - Meeting with Resident Council Representatives
    Section D - Selection of Resident Sample
    Section E - Tour Summation and Focus of Remaining Survey Activity
Task 3. Observation/Interview/Medical Record Review of Each Sampled Resident
Task 4. Drug Pass Observation
Task 5. Dining Area and Eating Assistance Observation
Task 6. Formulation of Deficiency Statement (if necessary)
Task 7. Exit Conference

Task 1. Entrance Conference

Perform these activities during the entrance conference in every certification and recertification survey:

1. Introduce all members of the team to the facility staff present at the entrance conference.

2. Explain the SNF/ICF survey process as resident centered in focus, and outline the basic steps.

3. Ask the facility to complete page 2 of form HCFA-519 (Resident Census) as soon as possible so that the information can be available for your subsequent tasks.

4. Ask the facility to post signs announcing that State surveyors are in the facility performing an "inspection" and noting the location where the surveyors are available to meet with residents in private. Place the signs in readily viewed areas (at least one on each floor). Handwritten signs with legible large printed letters are appropriate.

5. If the facility has a Resident Council, make arrangements to meet with the president and officers privately.

6. Wear identifying information at all times during the survey.

7. Inform the facility that resident interviews will be held privately in order to enhance the development of rapport as well as to allay any resident anxiety. Tell the facility that information gathered from resident or Resident Council interviews is always balanced with information from the tour, observations, discussions and records review as well as information given by facility officials. Point out that the facility will be given an opportunity to respond to all findings.

Task 2. In-depth, Integrated Tour

Purpose

The purpose of the tour is to:

1. Focus on resident-specific and resident-centered areas of care and treatment;

2. Assess the types and patterns of care delivery present within a facility;

3. Focus on physical environment requirements; and

Forms

For these tasks, use these forms:

HCFA-521 - Tour Notes Worksheet

HCFA-519 page 2 - Resident Census and Conditions of Residents

General

Allow approximately 3 hours for the in-depth tour. A high quality or very small home may take less time; a poor quality or very large home may take more time. Use your judgment to determine the pace and depth of the tour.

While touring, converse with residents, family members/significant others (if present), and staff. Ask open-ended questions in order to confirm observations, obtain additional information, corroborate information, or probe deeper as needed, e.g., accidents, decubitus ulcers, and special diets.

Respect the confidentiality of information provided and privacy of the residents, particularly in your timing and techniques for information gathering. Above all, do not disrupt the operations of the facility or impose upon any resident

Be alert for facility-wide or unit-wide patterns of care that are questionable and record any findings on form HCFA-521 Tour Notes Worksheet. Questionable patterns of care that can be readily identified through general observation are in these areas:

- grooming and personal hygiene;
- social/emotional needs; and
- restorative nursing needs

When recording observations about care and resident conditions, use an identifier other than name (e.g., Resident #1632) on the Tour Notes Worksheet.

Pursue leads and develop further as warranted. Should you find, for example, a soiled, bloodied and malodorous dressing on a resident, focus on areas of staff assistance, clinical techniques and infection control. Scrutinize, too, for other instances of this nature.

Section A--Resident Needs--Focus on each resident's needs, and whether or not those needs are being met. Resident needs may be physical, emotional, social, psychological, or spiritual.

Scan each resident for the following while touring:

--Personal Hygiene, Grooming, and Appropriate Dress

- --Position
- --Assistive and Other Restorative Devices
- --Rehabilitation Issues
- --Functional Limitations in ADL
- --Functional Limitations in Gait, Balance and Coordination
- --Hydration and Nutritional Status
- --Infection Control
- --Resident Rights
- --Activity for Time of Day (appropriate or inappropriate)
- --Emotional Status
- --Level of Orientation
- --Awareness of Surroundings
- --Behaviors
- --Cleanliness of Immediate Environment (wheelchair, bed, bedside table, etc.)
- --Odors
- --Adequate Clothing and Care Supplies as well as Maintenance and Cleanliness of Same

Observe interactions between staff and residents as well as between staff members. These interactions can provide insight into matters such as resident rights, and assignment of staff responsibilities.

In addition to scanning individual residents, focus on assessing the residents as a group, looking for overall patterns and trends of care.

For example, you might discover as you scan individual residents, that three-quarters of them are wandering aimlessly, sit and look into space or otherwise appear bored. Several of these instances would raise questions about patient activities programs.

As another example, you might note that several staff members do not protect each resident's privacy. That is, they do not appropriately robe and cover a resident being transported to the shower room or they change a resident's clothing with the room door open. A series of these incidents would show a pattern of disregard for resident rights.

Section B--Review of the Physical Environment.

When you observe a resident's room and auxiliary room, keep in mind the physical environment requirements. You need not document physical environment on the Tour Notes Worksheet. Instead, you may note these findings directly on the Survey Report Form in the remarks section.

Section C--Meeting With Resident Council Representatives.

If a facility has a resident council, meet with the representatives. Introduce all the team members and explain their disciplines as well as the purpose of the survey. Also indicate your interest in learning about the strengths of the facility in addition to any complaints or shortcomings. Indicate that this meeting is one part of the information gathering. The findings have not yet been completed nor the conclusions formulated. See section _____ on interviewing.

Use this meeting to:

1. ascertain problems, if any, from the consumer's perspective;

2. gather additional information about any patterns of care considered questionable by a surveyor;

3. obtain additional information or leads.

Likely concerns of the residents are:

1. Cleanliness and Atmosphere in the Facility
2. Nursing and Medical Care
3. Personal Care
4. Attitudes, Treatment, Dignity
5. Rights and Choices
6. Food
7. Activities

Conduct the meeting in a manner that allows for comments about any aspect of the facility. Use open-ended questions such as:

> "What is best about the cleanliness of this home? What is worst? What would you like to change?"

"What do you like about the medical care in this home? What don't you like? What would you like to change?"

In order to get more detail, use questions such as: "Can you be more specific? Can you give me an example? Tell me what you mean. What can the rest of you tell me about this?"

Above all, conduct the meeting so that the information and priorities come from the residents. If you wish to obtain information about a topic not raised by the residents, use an approach like the following:

"Tell me what you think about the food here. What would make it better?"

"What would you like changed? What don't you like? What do you like?"

Section D--Selection of Resident Sample.

The resident sample selection is to be performed in a random fashion. The percentage of residents from the population selected for the sample depends on the number of beds in the facility. State agencies may decide how the random selection will occur, such as every fifth resident from a listing of names or room numbers, starting at the end of the list and counting back. Whatever you devise, consider its usability for small as well as large facilities and use the same method for all selections of resident samples.

Determine the number of residents in the sample according to the following guide:

Number of Beds in Facility	Number of Residents to be Selected
Fewer than 60 beds	25% of the resident population
60-120	20% of the resident population
More than 120 beds	15% of the resident population

In conducting SNF/ICF surveys. State agencies must include an overall average of 20 percent of the total SNF/ICF resident population in the resident sample. Thus,

$$\frac{\text{Number of residents selected for in-depth review}}{\text{Number of total SNF/ICF resident population}} = 20\%$$

Section E--Tour Summation and Focus of Remaining Survey Activity.

When the in-depth tour is completed, discuss findings with team members and refocus as necessary. Transcribe Tour Notes onto the Survey Report Form in the "Remarks" column under the appropriate rule. Tour notes do not necessarily indicate the presence of a deficiency. It is important to transfer them to the Survey Report Form because findings from a later segment in the survey or gathered by another surveyor may combine to substantiate a deficiency. You need not check "met" or "not met" at this point in the survey.

Complete the listing of residents selected for in-depth review on the worksheet labeled "Residents Selected for In-depth Review" (form HCFA-520).

During the remainder of the survey, continue carrying "Tour Notes" worksheets in order to note findings as appropriate. Continue to observe all residents in the facility as well as those of the random sample, noting whether their needs also are being met. Summarize the issues at the completion of each survey task. For example, at the end of the tour you may conclude that overall, residents were clean and well groomed with restorative needs met; however, resident rights and appropriate activities were lacking for some residents. Transfer these findings onto the Survey Report Form in the "Remarks" section under the appropriate rule.

Task 3. Observation/Interview/Medical Record Review (OIRR) of Each Resident in the Random Sample.

Perform the in-depth review of the resident sample in order to ascertain whether the facility is meeting the needs of each resident. Evaluate specific indicators for each resident, utilizing the "Observation, Interview, Record Review (OIRR)" worksheet, (HCFA-524). Perform in-depth observations concurrently with interviews of residents, family/significant others, and staff interviews. Findings from these tasks will provide direction for the medical record review.

Perform the in-depth interview in a nonthreatening, and noninvasive fashion so as to decrease anxiety and defensiveness. Follow the procedures in section _______ Interview Procedures--General. The open-ended approach described for use in meeting with the Resident Council (see Section C, Task 2) is also appropriate for the in-depth interview. If an otherwise capable resident does not want to be interviewed, honor the resident's wishes. Do, however, perform the other activities of this task (observation and record review) for this and any other resident who declines an interview. If less than 40 percent of the residents in your sample are alert and willing to be interviewed, replace each resident that declines an interview and perform a complete OIRR for each one.

The length of the interview will vary based upon the condition and wishes of the resident and the amount of information supplied by the resident. The average interview, however, should last approximately 15 minutes. Courteously terminate an interview whenever a resident indicates inability or unwillingness to continue.

Some of the residents in the sample cannot be interviewed as reliably or as in-depth as others due to mental/physical conditions. Others will not be able to communicate at all. For those residents, observe the resident for level of awareness and orientation, types of behaviors, etc., and reconcile with staff and medical record review to assess whether the facility meets the resident's needs.

Observe and ask staff questions about the care and treatment rendered to residents as well as the technique and frequency. This information can corroborate findings from the medical record review and contribute to solid documentation.

Include the following areas in the observation/interview of all residents in the sample:

- Activities of Daily Living
- Grooming/Hygiene
- Nutrition/Dietary
- Restorative/Rehabilitation Care and Services
- Activities
- Social Services
- Resident Rights

Based upon your observations of the resident's needs, gather information about any of these additional areas, as appropriate. These include:

- Bowel and Bladder Training
- Catheter Care
- Restraints
- Injections
- Parenteral Fluids
- Tube Feeding/Gastrostomy
- Colostomy/Ileostomy
- Respiratory Therapy
- Tracheostomy Care
- Suctioning
- Other

Also be aware of poor resident outcomes and special care needs when observing and/or interviewing residents in the sample. Consider the examples provided below:

Potentially Poor Outcomes	Special Care Needs/Treatments
Odors	Intravenous/Blood Infusion
Progressive muscle weakness	Coma

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Inappropriate dress

Urine puddles/wet linens

Catheter bag on floor, unclean

Urine not clear/dark, bloody

Unresponsive/drowsiness

Withdrawal/depression

Poor skin integrity/sensation

Decubitus ulcer

Contractures

Edema

Lack of cleanliness/poor grooming

Disorientation/aggressive/disruptive /inappropriate behavior

Incontinent

Need for assistance in ADLs (restorative nursing)

Bedfast/wheelchair bound

Rehabilitation services

Vision, hearing, speech impairments

Recent return from hospital or new admission to facility

Diabetes

Restraints

Wounds/dressing

Foley catheter

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Lack of mobility with equipment

Underweight/overweight/emaciation/signs of malnutrition

Dehydration

Fractures

Accidents

Isolated residents

Inability to transfer

Paralysis

Spasticity, abnormal motor patterns

Swallowing difficulty

Document information obtained from the interview/observations on the OIRR Worksheet. Record in the "Notes" section whatever information you will need to specifically recall a resident's response (e.g., information to support a deficiency).

After completing the observation/interview activities, begin the record review. Note: you may prefer to initially perform the record review, complete resident/staff observations and interviews, and finally, return to the record for any final unresolved issues. Either method is acceptable and left to the judgment of each surveyor. Whenever possible, complete one resident's observation/interview/medical record review and document the OIRR before moving onto another resident. Depending on staff and resident schedules, there will be instances when almost all of the OIRR tasks are completed except for isolated matters such as observing a special treatment or talking to a specific staff member. In that case, move onto another resident before completing the review of the prior resident.

The resident record review is a two-part process. First, reconcile the observation/interview findings against the record to determine if (1) a proper assessment has been performed; (2) a plan with goals has been developed; (3) the interventions have been carried out, and (4) the resident has been evaluated to determine the effectiveness of the interventions. For example, if a resident has developed a decubitus ulcer while in the facility, record review can validate staff and resident interviews regarding the facility's attempts at prevention.

Second, reconcile the record against itself. That is, determine if the resident has been properly assessed for all his/her needs. Also, evaluate the record to insure that normal and routine nursing practices such as periodic weights, temperatures, blood pressures, etc., are performed as required by the resident's conditions. Include in this record reconciliation a few closed records to ascertain whether transfers and discharges were properly documented.

Thus, in the record review ascertain whether (1) appropriate assessments, planning, interventions, and evaluations indeed occurred, and (2) the records are sufficiently documented for routine nursing practices. Facilities, however, need not establish specific record areas stating "Assessment", "Plan", "Intervention", or "Evaluation" in order for the documentation to be considered sufficient.

Document your findings on the OIRR Worksheet, as appropriate; summarize the findings that are indicative of problematic or substandard care. This summary is helpful in determining the adequacy of care on a case-by-case basis. Be alert for trends or patterns of questionable care developing as the number of completed OIRR Worksheets increases. Do not transfer data from the OIRR worksheets to the Survey Report Form until all of the OIRR worksheets are completed and summarized.

Examine the findings of the sample as a whole.

- If the various problems in care or outcomes are related to a particular standard or condition in 25 percent to 49 percent of the residents in the sample, this suggests a compromised capacity by the facility to meet the health and safety requirements for participation in Medicare/Medicaid. In this situation, select another random sample of equal size and perform another IORR to ascertain the pervasiveness of the care and outcome problems. If problems in care/outcomes related to a particular standard or condition are present in 50 percent or more of the residents in both samples, develop and document for termination and follow the appropriate termination procedures in the section on adverse actions (section 3000 ff.)

- If the various problems in care and outcomes are related to a particular standard or condition in 50 percent or more of the sample (initial sample only), do not select an additional sample. Consider the problems so pervasive that they warrant adverse action.

NOTE: The problems related to a particular standard or condition could range from identical (e.g., meals not in accordance with dietary plan) to different but related (e.g., nursing services--lapse in care provided to two residents with catheters, one resident with contractures, three residents with poor hygiene and one resident with restraints).

If the situation in a facility warrants termination based on immediate and serious threat to patient health and safety, follow the procedures in section 3010 and related instructions. Cease further documentation of deficiencies.

Task 4. Drug Pass Observation

The Drug Pass Observation provides first-hand observation of the actual preparation and administration of medications to residents. For this activity, use form HCFA-522, "Drug Pass" Worksheet. You need not evaluate nurses notes or medication administration records for probable drug administration errors. Through observation, you can ensure that the finding are definitive. Deficient practices cannot be dismissed by claims that errors are merely in the documentation rather than in the administration.

Delegate the drug pass observation to only one surveyor who will observe approximately 20 residents. Residents selected for the in-depth review need not be included in the group chosen for the drug pass; however, their whole or partial inclusion is acceptable. Use your judgment as to the selection of timeframe and staff observed. Refer to SOM Appendix N for specific information on how to conduct and evaluate this portion of the survey.

Transfer findings noted on the "Drug Pass" worksheet to the Survey Report Form under the appropriate rule.

Task 5. Dining Area and Eating Assistance Observation

Because meal times are focused events during which the care of many residents can be observed, they are valuable in ascertaining how well the facility meets resident needs, particularly those requiring eating assistance. In addition to observing dining areas, observe residents who have their meals in their rooms.

For this task, use the worksheet entitled "Dining Area and Eating Assistance Observation" (form HCFA-523). Observe two meals and use one worksheet for each meal. If you prefer to show more than one meal observation per worksheet, clearly delineate the information gathered about each meal observed. Use your own discretion as to which meal(s) to observe. Give particular care to performing observations as nonobtrusively as possible. Chatting with residents and sitting down nearby may help alleviate resident anxiety over the observation process. Select a minimum of five residents during each meal observation to compare meals served with the diet card and physician orders. Expand the sample if there are questions about diet and/or diet orders for any resident in the sample, but focus only on the specific area(s) in question. Cease sampling when you have enough information to determine whether the care is or is not proper. As in other segments of the survey, enlarging the sample helps to clarify whether the questionable situation is an exception or the routine. It also supports a determination of adverse action, if any, with solid documentation.

Residents receiving improper care should be reported to the facility. Cite any deficiency under the requirements for therapeutic diets.

The dining observation also provides information on a wide range of nondietary issues. These include such items as staff interaction with residents, prompt and appropriate assistance, adaptive equipment usage and availability, as well as dress and hygiene appropriate for meals.

Ascertain how well the facility assesses, plans, and evaluates the nutritional care of residents and eating assistance needs by reviewing in-depth the sample of 10 or more residents. As with the other survey tasks, transfer the findings noted on the "Dining & Eating Assistance Observation" worksheet to the Survey Report Form.

Task 6. Forming the Deficiency Statement

The Survey Report Form must contain information about all the findings of the survey. Be sure to transfer to the SRF all data from the tour, drug pass observation, dining area & eating assistance observation, as well as in-depth review of the sample of residents. You may record the findings in the Remarks section rather than marking "met" or "not met," if desired.

Meet as a group in a pre-exit conference to discuss the findings and make conclusions about the deficiencies, subject to information submitted by facility officials that ameliorates the situation. (This supplements section 2724.) Review the summaries/conclusions from each task and decide whether any further information and/or documentation is necessary to substantiate a deficiency. This is a good point from which the pre-exit conference discussion can embark. (This supplements section 2722.)

Analyze the findings on the Survey Report Form for the following:

1. Severity--A finding directly related to the health, safety, and welfare of a resident(s) may be an isolated occurrence. However, because it is threatening the resident's emotional or physical well-being, that finding alone may warrant the issuance of a deficiency. For example, a resident may have experienced a change in physical condition that was not acted upon in a timely or appropriate fashion by

the facility, and complications developed that threatened the resident's physical and emotional well-being. Even though this may be an isolated instance, the severity of the situation and the effect upon the resident's well-being may warrant issuance of a deficiency.

2. Frequency of occurrence and/or the presence of patterns--For example, 2 of 10 residents in the sample display upper extremity contractures that are assessed and have current plans for appropriate intervention; however, that intervention is not occurring. The threshold at which frequency of occurrence equals a deficiency varies from situation to situation. Two out of 10 may be considered a deficiency. On the other hand, after discussion with facility officials, you may conclude that lack of intervention was warranted under the particular circumstances.

3. Adequacy of documentation--Review the adequacy of the explanatory statements for the findings on the Survey for each broad area reviewed, e.g., Nursing Service, Dietary, etc. For example, the findings on worksheets indicate that the food service delivery is disorganized, resulting in cold food being served. Have the findings on the worksheets been transferred to the Survey Report Form? Has all data been transcribed, i.e., food temperatures with the time and date? Are there any comments from residents or staff to transcribe for substantiation?, etc.

4. Combinations of problems--Combinations of problems in care such as poor grooming of a number of residents, lack of ambulation of a number of residents, lack of attention to positioning, poor skin care, etc., can yield a deficiency in nursing services just as 10 out of 10 residents receiving poor care for decubiti yields a deficiency. Additionally, be alert to certain other indicators that would follow from this deficiency in the provision of care itself. For example, a deficiency for insufficient staff should result if you note care problems and also note that available staff are busy but, in spite of their efforts, are not meeting the needs of the mix of residents. At the same time, a deficiency for supervision could result if surveyors note lack of care and aides sitting around the nursing area generally unoccupied throughout the duration of the survey. Finally, a deficiency for training could result if the provision of inappropriate care is observed and discussion with staff revealed that training courses were not provided, or the training was provided, but implemented inappropriately. However, the surveyor would not review the facility's training records in this situation.

5. Level of deficiency (element, standard, or condition--Decide if the findings are of sufficient severity, frequency, and substantiation to warrant the issuance of a deficiency at the level of element, standard, or condition.

When this analysis is complete, proceed with writing a deficiency statement. See section 2728 for instructions on the preparation. Also see section 3016 regarding documentation.

In accordance with your Agency's policy, present the Deficiency Statement and Plan of Correction (HCFA-2567), if needed, on site or after supervisory review. While the names of residents should not be indicated, it is important to be specific in the documentation. Sample items from a deficiency statement follow. Note the format--data prefix tag and regulatory citation, followed by a summary of the deficiency, and supporting findings. When the data prefix tag does not repeat the regulation, also include a short phrase that describes the prefix tag (e.g., F117 decubitus ulcer care).

D. Deficiency Statement

1. F75, F76 SNF 405.1121(k)--Each resident is not treated with consideration, respect, and dignity, and the resident's right to privacy during treatment was not always provided for as evidenced by the following:

> On 10/23 at 10:00 a.m. the nurse was observed applying a wound dressing to Resident #1620's inner thigh while the resident sat in her wheelchair in her room with the door open and no screening used.

On 10/23 at 9:30 a.m. staff members were observed entering Resident #1611's room without knocking on the door prior to entering. They gave no reason for being in the room and did not close the door when they left.

On 10/23 at 10:30 a.m., a custodian was observed entering Resident #1613's room. While the resident was reading the newspaper, the custodian turned on the radio, opened the bureau drawer, removed tissues because the custodian had a cold.

On 10/23 at 12:00 Noon a staff member standing and feeding resident #1625 was overheard to say "hurry up, hurry up."

2. SNF 405.1123(b) -- Each resident in the SNF has not had a physician's visit at least once every 30 days for the first 90 days after admission. Resident #1602 has not been seen by a physician since she was admitted 50 days ago. Her condition has deteriorated since that time (formulation of decubiti, infections).

3. F113 Provision of nursing services sufficient to meet nursing needs all hours of day.
F114 Treatments, medication and diet as prescribed.
F115 Daily personal hygiene
F116 Care to prevent skin breakdown
F117 Care to promote healing of decubitus including proper dressing

F118 Restraints ordered by physician, applied properly, and

released every 2 hours

F122 Infection control techniques

F123 Proper nursing and sanitary procedures and techniques

SNF 405.1124(c) -- The facility did not provide 24 hour nursing services to meet total nursing needs as evidenced by the following examples in the areas of grooming, appropriate dress, infection control, and proper care to prevent deformities, decubiti, and improper medication administration.

On 10/23 at 11:00 a.m., Resident #1641 was noted to be up in the lounge in his wheelchair dressed in his own clothes, but feet were bare.

On 10/23 at 10:45 p.m., Resident #1629 was noted to be up in a geri-chair in the activity room, dressed only in a gown and socks with her legs only partially covered by a lap robe. No shoes/nor robe.

Resident #1602 has Stage III and Stage IV decubitus ulcers on the outer aspect of her left ankle and dorsum of foot (1" x 1" and 1.5" x 1"). This resident has unmet needs resulting in skin breakdown, nutritional problems, poor personal care, and infection. Resident's hair oily and uncombed. Lips dry and cracked. Skin reddened on elbows and between knees, open area on left hip (pea sized). These were not assessed or acted upon by nursing staff. Found in bed with head of bed rolled up. Resident slid down to foot of bed. No footboard. No pillows for positioning. Urine smell in room. Purulent and odorous drainage from foot decubiti and sacral decubitus (2 1/2 cm. xx 3 1/2 cm deep). No wound cultures done. On 10/24 RN noted to not wash hands before or after decubitus care. Laid the soiled dressing on overbed table next to sterile dressing and later disposed of the used dressing in the wastebasket in the resident's bathroom.

Resident #1609 on 10/23 at 10:00 a.m. was observed with unkempt hair, bath blanket for lap robe.

Resident #1613 restrained in geri-chair for three hours without release on 10/23. At end of three hours, resident had episode of urinary incontinence.

Resident #1621 noted on 10/23 to have assistive device for dressing which was broken 10 days ago. Reported to staff, but no word from staff as to when it will be repaired.

Resident #1606 being ambulated by one nursing assistant on 10/23 in hallway wearing socks, but no shoes.

Resident #1611 on 10/24 was noted dressed in a faded dress with spots of dried food noted on it, sweater buttoned unevenly, not wearing stockings, bra, or slip. Undershirt showing at neckline. Facial hair evident. Dirty untrimmed fingernails. Skin flaky, dry lips. Sores on arms, stress incontinence, and leg bruises.

Task 7. Exit Conference

This supplements the instructions in Section 2724. The purpose of the exit conference is to inform the facility of survey findings and to arrange for a plan of correction, if needed. However, before formally citing deficiencies, discuss any allegations or findings that, for a variety of reasons, could not be substantiated in earlier tasks in the process. For example, if information is gathered that suggests a newly hired R.N. is not currently licensed, ask the facility officials to present current licensure information for the particular nurse in question.

Keep the tone of the exit conference consistent with the character of the survey process--inspection and enforcement. Tactful, business-like, professional presentation of the findings and determination of compliance or non-compliance with the regulatory requirements is of paramount importance. Although deficiency statements continue to depend on surveyor professional judgment, support your conclusions with resident-specific examples (identifiers other than names). Refer to the section (__________) on "Role of the Surveyor" for discussion of the limited function of consultation.

PLAN OF CORRECTION

This supplements section 2728. Explain to the facility that your role is to identify care and services which are not consistent with the regulatory requirements, rather than ascertaining the root causes of the deficiencies. (See section ________.) Each facility is expected to review its own care delivery system. Following the exit conference, each facility is required to submit a plan of correction that identifies necessary changes in operation that are believed to assure correction of the cited deficiencies. Plans of correction specific to residents identified as examples of improper or inadequate care are acceptable only where the deficiency is determined to be unique to that resident and not indicative of a possible systemic problem. For example, an aide is absent so residents John Jones and Mary Smith are not ambulated three times that day as called for in their care plans. A plan of correction that says "ambulate John Jones and Mary Smith three times per day," is not acceptable. Rather, this deficiency is indicative of a systemic problem--staff scheduling and supervision. An acceptable plan of correction would explain changes made to the facility's staffing and scheduling in order to guarantee that staff is available to provide all necessary services for all residents. It is incumbent on the facility not only to show intent to correct the deficiency, but describe or demonstrate how it will correct the deficiency.

Acceptance of the plan of correction does not absolve the facility of the responsibility for compliance should the implementation not result in correction and compliance. Acceptance should be considered as the State agency's acknowledgement that (1) the facility has a reasonable approach for correcting the deficiencies; and (2) compliance is expected.

PAPER FLOW AND FOLLOW-UP

When the exit conference is completed, the State survey agency retains the various survey worksheets as well as the Survey Report Form. Forward the deficiency statement to the HCFA regional office. Follow the procedures in sections 2762-2766, as appropriate.

For follow-up on plans of correction, ascertain the corrective status of all deficiencies cited on the HCFA-2567 and follow the applicable procedures in sections 2732-2776. Re-evaluate the specific types of care provided to residents that were identified as deficient. If the deficiencies continue to exist, consider the facility's status as non-compliant, and follow the applicable procedures in Part III Adverse Actions.

INTERVIEW PROCEDURES--GENERAL

Because this survey process focuses on direct patient assessment, be mindful of the physical and emotional well-being of the residents.

Assure that each resident is interviewed by only one interviewer, in private, and no more often than once per day.

At each interview:

1) Introduce yourself.

2) Address the resident by name.

3) Explain in lay terms the reason for your visit (e.g., assure the health and safety of the residents).

4) Briefly outline the process--entrance conference, tour, interviews, observations, review of medical records, resident interviews, exit conference.

5) Mention that the selection of a particular resident for an interview is not meant to imply that his/her case is substandard or that the facility provides substandard care.

6) Assure that you will strive for anonymity for the resident and that the interview is used in addition to medical records, observations, discussions, etc., to capture an accurate picture of the treatment and care provided by the facility.

7) When residents experience difficulty expressing themselves:

- avoid pressuring residents to verbalize
- accept and respond to all communication
- ignore mistakes in word choice
- allow time for recollection of words
- encourage self-expression through any means available

8) When interviewing residents with decreased receptive capacity:

- speak slowly and distinctly
- speak at conversational loudness
- sit within the resident's line of vision

9) While prolonged time expenditure is not usually a worthwhile use of resources or the resident's time, do allow time at the beginning of the interview to establish rapport. Performing the above six actions should help to accomplish this aim.

10) Listen to all resident information/allegations without judgment. "I see" is a non-judgmental response. "What a terrible way to run a nursing home" is not appropriate, for each allegation must be corroborated. Moreover, information gathered in a subsequent activity of the survey may well repudiate the allegation.

FORMS UTILIZATION

Utilize the forms for this process in an interrelated fashion. Use the Survey Report Form for skilled as well as intermediate care facilities. Regulations provided on the survey form should be applied in the following manner:

o	Freestanding Skilled Nursing Facility (SNF)	Apply SNF regulations.
o	Freestanding Intermediate Care Facility (ICF)	Apply ICF regulations.
o	SNF Distinct Part of a Hospital	Apply SNF regulations.
o	ICF Distinct Part of a Hospital	Apply ICF regulations.
o	Dually Certified SNF/ICF	Apply SNF regulations and 442.346(b).
o	Freestanding SNF with ICF Distinct Part (Regardless of the proportion of SNF and ICF beds, the facility type is	- Apply SNF regulations for SNF unit. - Apply ICF regulations for ICF distinct part.

determined by the higher level of care. Therefore, LTC facilities with distinct parts are defined as SNFs with ICF distinct parts.)

- Apply both SNF and ICF regulations for shared services (e.g., dietary).
- If the same deficiency occurs in both the SNF and ICF components of the facility, cite both SNF and ICF regulations.

WORKSHEETS AND FORMS GUIDE

Use the form HCFA-519 for all SNF and ICF initial and recertification surveys. Use the form HCFA-525 for all initial surveys of SNFs and ICFs. See Exhibit 63 for the list of documents in the certification packet. In addition, a guide for using the worksheets follows:

Title	Instructions	Amount
Face Sheet (HCFA-525 and HCFA-519)	--Complete all areas with the assistance of the facility. --Submit with complete survey packet.	One
Resident Census	--Complete all areas with the assistance of the facility.	One

(HCFA-519, page 2)	--Each total within the blocks of descriptive information regarding residents is to equal 100% of the resident census, except the block in the lower right hand corner of the second page. --Submit with complete survey packet.	
Tour Notes (HCFA-521)	--Utilized by all surveyors in facility. --Maintain notes regarding resident findings at any time while in the facility. Physical Environment findings need not be noted on this form. They may be documented directly on the Survey Report Form. --Each surveyor transfers problems found to Survey Report Form under appropriate rule in column labeled "Explanatory Statements." --Maintain in State office.	One or more per survey

Residents Selected for In-Depth Review (HCFA-520)	--Completed by surveyor who performs the random sample. --Fill out name (e.g., Mrs. M) or identifier of resident. --Maintain in State office.	One
Drug Pass Worksheet (HCFA-522)	--Completed by surveyor while observing the drug pass. --Findings transferred to survey report form under appropriate rule in column labeled "Explanatory Statements". --Maintain in State office.	Two or more
Observation/ Interview/ Record Review (HCFA-524)	--Completed by surveyor(s) while observing and interviewing the residents in the random sample. --Under ADL Section, check box if assistance is needed.	One per resident

--For the remaining sections, check if condition or problem exists. Leave blank if applicable to resident but is not a problem. Use NA if not applicable.

--The record review portion is completed separately from the interview/observation time. Complete as the surveyor reconciles observation/interview findings with the record and the record against itself.

--Complete the observation/interview/record review on a resident-by-resident basis, drawing together a summary of problematic findings or conclusions, and noting that summary in the "Notes" section.

--Transfer negative findings and conclusions to survey report form under appropriate rule in column labeled "Explanatory Statements." All information regarding each resident need not be transferred. Instead the note may read "See OIRR for resident # ___ re: poor catheter care."

--Maintain in State office.

SURVEY TEAM

The survey team for the SNF/ICF survey should consist of no less than two nor more than four members. If the bed size of the facility is greater than 200 and the duration of the survey is greater than 2 days, additional members are acceptable. At least one registered nurse must be on the team. The disciplines of the additional members are at the discretion of each State agency, as appropriate to a facility's compliance history.

Use the following survey team model:

SNF/ICF Survey Team Model

Average on site time per survey: 60 person hours (Number of surveyors X number of hours on site)

2 members: At least one RN plus another RN, a dietitian or a pharmacist.

3-4 members: In addition to the two members of a two-member team described above, one or two members of any discipline such as a social worker, sanitarian, etc.

5 or more members: If the facility has over 200 beds and the survey will last more than 2 days.

Select additional disciplines needed to complete each survey, based on the facility's performance history. Utilize dietitians and pharmacists to the maximum extent possible.

ROLE OF SURVEYOR

The primary role of the surveyor is to assess the quality of care provided by a health care facility. In performing Medicare/Medicaid survey activities, the surveyor is charged with ensuring that the facility is in compliance with all the conditions of participation as set forth in the Federal Code of Federal Regulations. The surveyor's responsibility is to advise the facility management of deficiencies identified during the course of the survey and to ensure that appropriate action is taken to correct the deficiencies. As such, the survey process is properly characterized as an inspection and enforcement process.

Included in the inspection and enforcement role is a consultation function. Among the surveyor's responsibilities both during and after the onsite visit is the identification of deficiencies in accordance with specific regulatory requirements in an effort to assist the provider or supplier in complying with deficient conditions. This identification and communication of the deficiency to the provider or supplier is referred to as "consultation" in the regulations (42 FR 405.1903(a)). This type of consultation, however, does not include professional technical advice on how a specific deficiency might be corrected. It is HCFA's policy that facility operators, who are in business to provide a certain type of health care, should be fully qualified to independently manage and operate their institutions in accordance with good business practice. If a facility needs the services of a professional consultant to advise them on business or health related matters, then they should undertake to hire one. Surveyors should not provide such consultation since budget allocations to the States for surveyor staffing resources do not include funding for consultative services. Also, the surveyor's role as inspector and enforcer may be compromised if the surveyor approves plans of correction that accommodate only the surveyor's suggested remedial action and do not necessarily address the real problem. While the facility operator might find it easier to simply adopt the surveyor's suggestions, there is no assurance that the surveyor has found the real root cause of the deficiency. For example, if a surveyor in a nursing home learns that residents are being served cold meals, it is not the surveyor's responsibility to determine the root cause (e.g., lack of aide training in food service, meals not properly cooked, food warmers broken, etc.). Rather, the surveyor should simply indicate that food is being served cold. The facility management should determine what caused the problem and submit a plan of correction to address it. The surveyor, on returning to the facility for a followup, should not look to see if the facility has taken the action indicated on the plan of correction, but should rather make a determination based on interview and observation that the food, in fact, is not being served at the proper temperature.

Finally, while surveyors should never function as consultants, and should not delve into the facility's policies and procedures to determine the root cause of a deficiency, surveyors should point out an obvious problem that has surfaced either during the survey itself or at the exit conference. For example, a surveyor should point out that he or she noticed that the temperature control on a food warmer device was set at an improper level.

LONG TERM CARE SURVEY

CARE GUIDELINES

September 1986

LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
Residents Rights F44 SNF 405.1121(k) (1) F45 ICF 442.311(a) A. Information*		Ask Resident o Did you recieve a copy of the Residents' Bill of Rights? Was it explained to you?	Look for signed acknowledgement of receipt of resident rights information. Residents unable to sign name may have their "mark" witnessed. Look for written statement of charges for services Social Work records may indicate patient rights information discussed with resident.	Because of the confusion surrounding admission to a new facility and the large amount of information given to a resident or resident's family on admission, information given at this time is often forgotten. Written information on services and costs must be given to the resident, as well as copies of residents rights and responsibilities. Copies of residents' rights should also be posted in locations available to patients and visitors, e.g., in resident lounges, lobbies, or other area where residents and visitors could easily see and read them.	Notification of Change in Status 405.1121(J) 442.307 Patient Care Policies 405.1121(e) 442.308 442.309 442.310 442.305 Medical Direction 405.1124(a) 442.338 Medical Records 405.1132 (b)(d) 442.310
F46 1. Rights and Responsibilities	Is information concerning resident rights and responsibilities posted in the facility?	o Were you told of any responsibilities you have in living here?			
F47 2. Rules of Resident Conduct		o Were you given a chance to ask questions?			
F48 3. Resident Acknowledgement		o Did he/she receive a written copy of services provided by the facility and any additional costs for these services?			
F49 4. Resident informed in writing of changes in services and charges for services.		o If there are changes in services or costs does someone explain these? Ask Staff			
F50 5. Information to resident of services not covered by Medicare or Medicaid and not covered in the Basic rate		o How do residents learn what is expected of them? o How do they learn about any changes in the facility's procedures and or/costs?			

INTENT

To assure that the resident maintains, in so far as possible, those personal rights that are a part of normal, adult life, and including the right to personal dignity.

*Information concerning incompetent residents is given in L. Delegation of Rights and Responsibilities

LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
B. Medical Condition & Treatment F51-55 405.1121(k)(3) 442.311(b)		**Ask Resident** o Has your doctor discussed your health with you how is it, what's wrong, and what you can expect in the future? o Have you had the opportunity to help plan what you need and how you are taken care of? o Do you know that you can refuse treatment or Medication? o Have you ever refused Medication or treatment? o What happened when you did? **Ask Staff** o Is the facility participating in any experimental research? o If yes, ask what residents are involved. Interview a sample of these residents. **Ask Resident (or Guardian)** o Are you participating in the _____ study? o Was this explained to you well enough so that you understand what the study is about and any risks that may be involved?	If the resident has not been informed of his/her Medical condition, physician notes should document that the resident was not informed because it was medically contraindicated. Do care plans or other documentation reflect resident participation in care planning? If resident states he/she has refused treatment or medication does documentation indicate adherence to/violation of resident rights. Review records of residents identified as participating in a clinical research study. Are informed consent forms signed? Do these signed forms list all known risks for the resident?	Unless there is documentation that the residents medical condition should not be discussed with him/her resident interviews/record reviews should indicate that the resident and physician have discussed his/her medical condition.* If you cannot confirm that this has occurred, interview staff to get further clarification. Almost all residents who are not comatose are able to participate to some extent in their care planning-you should find evidence of this for the majority of the residents. Residents do have the right to refuse Medication or other treatment, but you would expect that the facility would discuss the implications of this refusal with the resident and possibly do some "gentle persuasion".* However, except in an emergency situation force should never be used to compel a resident to accept Medication or treatment.* Deceit is also a violation of resident rights., i.e., medication placed in food. Any resident participating in research studies should fully understand the implication to themself, of the study. The facility is no in compliance with the resident rights regulation if the resident consents to participate in a clinical study without full knowledge of the study. (Record review only as other non-clinical studies may not require informed consent.)	Patient Care Managemt. 405.1124 (d) 442.319 442.341

*If resident adjudicated to be incompetent, guardian should fulfill residents role.

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LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
C. Transfer & Discharge F56-58 405.1121(k)(4) 442.311(c)(1)(2)(3)	Look for residents that may be inappropriately placed physically-i.e., an alert resident rooming with a confused, noisy resident; very ill resident placed far from the nurse station; residents not compatable with each other e.g., different life styles, habits etc.)	Ask Resident o Have you ever been moved from one room to another? o If yes, why? o How were you involved in the decision to move? o How much time was there between the time they told you you were to be moved and when you were moved? o If you asked to have your room changed? To Ask Direct Care & Other Staff o What are some of the reasons residents rooms are changed? o What are some of the reasons for discharge of residents or transfer to a hospital or another LTC facility? o How are residents involved in the decision to move? o If a resident requests a room change, how is this handled?	Nursing, physician, and/or social service progress notes should indicate reasons for transfer and discussion with resident and/or family/guardian. If staff interviews give you cause to feel that transfers and discharges may be in violation of these regulations, review a sample of closed records for transfer information how would that be handled? If residents are being transferred between facilities with common ownership and similar levels of care, transfers must be reviewed to determine reasons for transfer. Efforts to maintain the census is not an acceptable for transfer. Do discharge records review for: -reason for discharge, Medical non-payment need for different level of care:	To be in compliance with Transfer and discharge regulations the facility must be able to confirm that all discharges/transfers were for Medical or resident welfare reasons, or non-payment. Welfare reasons include physical, emotional, social issues. Not acceptable are transfers and discharges made for the convenience of the facility.	Status Change Notification 405.1121 (j) Medical Records 405.1132 (c)(e) 442.318 (c)(4) Transfer Agreement 405.1137 (a)(2) 442.307 (b)(1)(i).

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LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
D. Exercising Rights F59 -61 405.1121(k)(5) 442.311(d)(1)(2)	Do residents appear comfortable when speaking to the surveyors as opposed to being afraid that someone may see them or overhear their conversation?	**Ask Resident** o Do you belong to, or take part in, resident council activities? o Are you informed of changes in the facility that will affect you and are you given a chance to express views on these changes prior to their implementation?		Compliance determinations will be made based primaril[illegible] resident/staff intervi[illegible] and the correlation of interview information with documentation in the Medical record. If residents ask, they should be allowed to speak to the surveyor without facility personnel being present	Residents Rights 405.112(k) 442.311 Social Services 405.1130 442.344
	Look as sign in/out record for last election day for ambulatory residents who went to the polls rather than using an absentee ballot.	o Does the facility assist in arranging for you to vote either on the polls or via absentee ballot?			
		o Are you assisted in obtaining legal or Social Services if needed?	Review social work progress notes for legal referals.		
		o Do you feel confortable in expressing yourselve freely or are you concerned about retaliation?			
		o Is staff/administration responsive to complaints? Do you know who to complain to?	Is there documentation in progress notes or elsewhere, of resident complaints and disposition of complaints?		
		Ask Staff o What arrangements are made for residents to vote?			
		o How do you handle it if someone needs a lawyer or other service that you don't provide?			

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LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
E. Financial Affairs F62-69 405.1121(k)(6) 442.311(e) 405.1121(m)		**Ask Residents** o Are you able to take care of your own financial affairs? o Does the facility keep some money for you that you can have when you request it? o When you ask for this money, how quickly do you get it? o Do you know the amount of money you have available at this time?			Social Services 405.1130 (a).
		o If the facility pays bills for you do they periodically give an itemized listing of the transactions they have made?	A copy of the statement should be in the residents financial record and given to the resident at least quarterly.	Residents should have reasonable access to their funds (may not be available at 2A.M.) and should have at least a quarterly accounting of their funds.	
		o When was the last itemized statement that you received?	Receipts, account logs showing deposits, withdrawals, authorization/reasons for withdrawal, and interest earned should be reviewed in depth interview, if resident indicates there may be a financial problem.	If questions arise they should be resolved	
		o Are you comfortable that your funds are taken care of correctly? o If you deposit money or valuables with the facility do you receive a receipt for this deposit. o Are you or your family able to review your financial records when you request to do so. o Have you every had money or anything else stolen? o If so what was done about it? o Does the home provide safe-keeping for valuables? o Have they ever lost anything of yours?		Personal possessions and funds received from the residents should be protected from theft and other loss. If losses do occur there should be: 1. a procedure which is implemented to investigate the loss, 2. a plan to prevent a recurrence; and 3. a system for compensating the resident. Resident funds must not be appropriated for facility furnishings, linen, supplies, etc.	
		Ask Staff o What is your procedure when residents lose personal belongings? Valuables? o How are resident personal funds handled? o What is your procedure when a resident asks to get an accounting of their funds?			

*The special needs of residents with alzheimer's disease who "lose" personal possessions should be noted. Individuals in stages 2 & 3 of Alzheimer's disease sometimes think their personal possessions were stolen.

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LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
F. Freedom From Abuse and Restraints F70-74 405.1121(k)(7) 442.311(f)	-How many residents are physically restrained? -What type of restraints are used? -Are they applied correctly? -What is the apparent physical/mental condition of those residents restrained? -Do you observe the release of restraints ev. 2 hrs. & the provision of at least 10 mins. exercise for the resident?	Ask Resident o Why are you wearing this? o Are you comfortable with this restraint? o How often is this worn? o Do you know what would happen if it were removed? o How often is it removed? o What is done for you when the restraint is removed? o For nonrestrained resident-- -Have you ever been restrained? -For what reason? -What explanation was given for the restraint? o Do you ever feel that you receive medication when you don't need it?	Look for a physicians order for the restraint. Review nurses, physicians progress notes re: reason for restraints and resident reaction to them. Also any alternative methods tried; What time of day are they most often applied. Review schedule of releasing restraints. Care plans -when restraint is to be used -For how long. -What are plans for alternative measures. -Is the resident periodically re-evaluated. If appropriate are Social Service and activities department involved?	There must be a physician's order for all restraints, including "safety devices" which are defined in some State laws Progress notes should show evidence that methods other than restraints were initially used to protect the resident from injury, and that restraints were used only when other methods were not adequate If used in an "emergency" the reason for use must be documented and show that a. Its use was necessary to protect the resident from injury. b. Its use was necessary to protect others from injury The resident must be observed by a staff member at least every 30 min. while restrained The restraints must be released and the resident exercised, toileted, etc. at least every 2 hours. The restraint must be applied correctly.	

LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
	-How often are restrainted residents observed by staff?	Ask Staff o What is the facility policy re: restraints? o What is considered an "emergency" need for restraints?	Who authorizes the use of restraints in an emergency? Do progress notes indicate that a professional staff member authorized the use of "emergency" restraints.	If the use of restraints increases during evening and night hours review progress notes and staffing to make a determination as to whether the restraints are justified or if they are for staff convenience.	
	-Observe affect on residents. Do you see what may be signs of over-Medication?	o What is the most common reason for use of restraints?	There should be documentation that the use of "emergency" restraint has been promptly reported to the residents physician.	Care plans should plan not only for care while the resident is restrained but should show effort to find alternative treatments to restraints, or there should be documentation in the medical record that no alternative is appropriate	
	-How often is this observed?	o Do you try any alternative measures before using restraints? o What information do you give the physician to help him make the decision to order restraints?			
	-Residents should be free from mental & physical abuse.	o What do you routinely do for the resident when you periodicaly release the restraints?		An appropriate drug regimen review should be conducted on the resident.	
	-Observe interaction of staff and residents for any sign of harrassment, humiliation or threats.	o Does use of restraints increase on evenings & nights when there are fewer staff members? o Have you had any accidents or incidents in the last year while residents were restrained?		Your observations should show interaction between residents and staff to be, except in unusual situations, free from tension and hostility	
	-Do residents appear comfortable with staff.	o How do you define the difference between a "safety defice" and a "restraint"? o How do your policies differ in regard to "safety devices" and restraints?	Does the drug regimen review indicate appropriate use of psychoactive drugs?	Staff should step into situation where one resident may be abusing another	
	-Look for numbers of residents with bruses or other injuries (skin of the elderly bruises easily, so do not automatically assume abuse or injury.	Ask Resident o Do you feel safe in the facility? o Do you ever feel intimidated, harassed, or otherwise abused? o How are confused residents treated? o Is anyone ever hit or treated roughly?	Do progress notes and care plans by all disciplines show an caring, concerned attitude? Are there resident complaints documented? What is the resolution of these complaints?	Resident should feel free to voice complaints. If no complaints are noted in records or on record review, why not? Residents should seem comfortable in relating how they are treated?	
	-Observe resident to resident interactions & staff response to any physical or mental abuse of one resident to another.	o Do you feel as if you are treated with respect/dignity? o Is the staff/administration responsive to complaints? o Do you know who to complain to?			

LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
G. Privacy F75 -F80 405.1121(k)(8) 442.311(g) (9)(14)	-Observe inter-actions between staff & residents for indications of respect, consideration, dignity and individuality.	**Ask Residents** o Do you feel that you are treated as a worthwile, adult indivudual?	Review progress notes for indications that staff sees resident as an individual--i.e., resident eats breakfast in bed because he/she enjoys it.	Observations and interviews will give you information to determine if residents are respected and treated as individuals.	Residents Rights 405.1121 (k)(7) 442.311(f)
		o Are you given the opportunity to make choices in your life within the facility? e.g., are all residents "put to bed" at the same time?	Signed consent for release of information.	If privacy is not provided--i.e. no private place to met or make phone calls, not allowed to shut door when having visitors, etc.	
	-Observe for evidence of resident neglect, residents left in urine/feses without cleaning.	o When you are being cared for, are you comfortable? o What is the degree of privacy and respect you receive?	Do maintenance of and content of medical records indicate that confidentiality is practiced?	Medical records should not be left where unauthorized personnel can read them and there should be identification codes needed to access computerized records.	Medical Records 405.1132 (b) 442.318(d)
	-How do staff members enter a residents room or go behind a privacy curtain?				
	-Are privacy curtains used or doors shut when personal care needs and/or treatments are rendered?	o Do you feel comfortable that if the door to your room is closed staff will knock or otherwise make their presence known before entry? o Do you have a private place to make telephone calls?		Married residents should be sharing rooms if they desire to do so unless there are appropriate contradictions.	
	-are there areas for residents to be alone or meet in private with visitors?				
	-Do you see residents being given choices in many aspects of their lives-i.e., where to eat, when to get up, what to wear, what medications to take, etc.?	o Are your medical records and condition kept confidential? o Can you see your record if/when you ask? o Has any information about your condition been given to someone outside of the facility without your permission?			

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LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
	-Are medical records kept in their assigned spots not carelessly left for nonauthorized persons to view? -Are married residents sharing rooms? -Observe for negative attitudes toward aging-infantilization and patronizing of residents. -If residents undress in public area, how does staff handle this? -Listen to staff conversation in public places (elavator, lobby) are resident issues being discussed?	o For married residents: -When your husband/wife visits can you shut your door and be assured of privacy? -Can you ask that you not be disturbed and have that request respected? Ask Staff o What is done to assure that each resident maintains his/her dignity and individuality? o How are medical records kept secure? Who has access? o Do you have married couples here? o Do they share rooms? o If not, why? o What arrangements do you make for husband and wives or significant others to visit? o Do you allow their door to be closed? o Can you adhere to a request that they not be disturbed?			

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LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
H. Work FR: 405.1121(k)(10) 442.311(h)	-Are residents doing any type of work such as picking up dirty trays, pushing laundry hampers, etc.?	Ask Residents o Are you ever asked to help out in the facility such as pick up dirty trays or stamp mail? o If yes, do you do this?	If residents are performing services for the facility, is that included in their care plan with specific therapeutic goals defined? If appropriate does the family concur? Are results documented in process notes?	Services performed by a resident should be part of the resident's plan of care and should be done only if the resident is in full agreement. Rewards are identified and not taken from residents own funds.	
	-What about clerical work?	o Do you want to, or do you feel it is expected of you? o Do you feel you can say "no"? Ask Staff o Are residents asked to help with facility staff if you are short-handed? o What is their reaction? o What useful work is available for residents who want to/need to be usufully "employed"?	What service (activities, nursing, etc.) is responsible for planning reevaluating and adjusting work activity. Look for physician's orders for approval or disapproval of work activity or restrictions on this activity. Should include the amount of time and services to be performed.		

LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
I. Freedom of Association & Correspondence F82-81 405.1121(k)(11) 442.311(i)	-Are there areas in the facility-i.e., small lounges, etc., where residents can and are meeting privately? -Is mail delivered opened or unopened? -Are facility personnel assisting residents, if needed, in opening and/or reading mail?	Ask Residents o Can you have visits from anyone they wish? o Can you find a private place to visit? o Do you receive their mail unopened unless they request otherwise? o Are there telephones you have access to? o Does the staff or volunteers assist you in reading or sending mail, if needed? Ask Staff o Where do residents go when they want privacy? o What telephones are available to residents? o What is your visiting policy?	Physician orders and care plans for indications of restrictions on visitors and/or receiving and sending mail.	All patients may have access to and maintain contact with the community of which they are a part and members of that community have access to him. Subject to reasonable scheduling restrictions, patients may receive visits from anyone they wish. A particular visitor may be restricted by the facility for one of the following reasons: -The patient refuses to see the visitor. -The patient's physician documents specific reasons why such a visit would be harmful to the patient's health. -The visitor's behavior is unreasonably disruptive of the functioning of the facility (reasons are documented and kept on file). Decisions to restrict a visitor are reviewed and reevaluated each time the patient's plan of care and medical orders are reviewed by the physician and nursing staff or at the patient's request. Space is provided for patients to receive visitors in reasonable comfort and privacy.	Resident Rights 405.1121 (k)(8) 442.311(g)

LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
				Telephones, consistent with ANSI standards (45.1134(C)), are made available and accessible for patients to make and receive calls with privacy. Patients who need help are assisted in using the phone. The fact that telephone communication is possible, as well as any restrictions, is made known to patients. Arrangements are made to provide assistance to patients who require help in reading or sending mail	

LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
J. Activities F84 405.1121(k)(12) 442.311(j)	-What planned activities are occurring? -What unplanned activities are occurring--individual, 2 or 3 persons, or a group. -If there is a facility chapel, is it open? -Are activities posted at wheelchair level and kept up to date? -Are residents lined up in front of a T.V. in a common room for hours?	Ask Residents o What do you like to do? o What did you do yesterday? (compare answers) o Is participation in activities optional? o Are you encouraged to participate? o Is pressure exerted on you to attend specific activities? o Which ones? (Surveyors should be aware of special encouragement--"gentle persuasion", which might be important for the depressed or withdrawn resident.) o Are residents notified of community activities? o Are arrangements made for transportation, etc. so that residents can participate? o Can residents go to religious services if they wish? Ask Staff o Are arrangements ever made to take residents to community activities? o Do friends and relatives ever take them? o Do your residents attend religious services of their choice? o How are residents kept informed/notified of activities?	Care plans or other documentation should indicate resident preferences for both facility and non-facility planned activities. Progress notes of responses to activities.	Compliance with this element is determined by evidence that residents are given the opportunity to participate in activities as wished unless medically contraindicated. They must not be forced to participate against their wishes.	Patient Activities 405.1131 (b) 442.345 (a)(c)

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SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
K. Personal Possessions F85 405.1121(k)(13) 412.311(k)	-Are residents wearing their own clothing or facility night-gowns, robes, etc.?	Ask Residents o What clothing and personal belongings can you have? o Is there a place that you can secure any valuables that you may not want to keep in your room?	Admission notes should list any personal property secured by the facility. Admission notes should indicate how personal clothing will be laundered.	Patients are permitted to keep reasonable amounts of personal clothing and possessions for their use while in the facility and such personal property is kept in a safe location which is convenient to the patient. The amount that is reasonable will be dependent on space available in the facility.	
	-In resident rooms observe for personal belongings. -Ask residents if you can look in the closet--is personal clothing in there? -Ask residents if belongings such as clothing are identified with name tags or other identifying methods? -Is there enough space to store clothing?	Ask Staff o What personal belongings may residents have? o What do you do to secure valuables and other personal property?		Patients are advised, prior to or at admission, of the kinds and amounts of clothing and possessions permitted for personal use, and whether the facility will accept responsibility for maintaining these items (e.g., cleaning and laundry). Any personal clothing or possessions retained by the facility for the patient during his stay is identified. The facility is responsible for secure storage of such items and they are returned to the patient promptly upon request or upon discharge from the facility.	

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LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
L. Delegation of Rights & Respons-ibilities F86-88 405.1121(k) 442.312		**Ask Staff** o When do you have relatives make decisions for residents-i.e., how do you decide when the resident isn't capable of making decisions himself? o Are any legal steps taken? **Ask Resident and/or Guardian** o Do you feel that you are given all pertinent information? o Do you have the opportunity to make decisions re: care, etc.? o For guardian: are you notified/informed in a timely manner as appropriate?	Review physician progress notes--incapability must be documented. Is there clear documentation as to whom rights and responsibilities have been assigned? Are pertinent consents/documents signed by appointed guardian?	The fact that a patient has been adjudicated incompetent, is medically incapable of understanding, or exhibits a communication barrier, does not absolve the facility from advising the patient of these rights to the extent the patient is able to understand them. If the patient is incapable of understanding these rights, the facility advises the guardian or sponsor and acquires a statement indicating an understanding of patients' rights. The surveyor reviews records of patients selected for indepth review who are classified either incompetent, medically incapable of understanding their rights, or have a communication barrier to verify documented evidence (signed acknowledgment) that the guardian or other sponsor has been advised of these patient rights and understand their role in acting on behalf of the patient.	Residnent Rights 405.1121 (k)(1) 442.311(a)

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LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
STATUS CHANGE NOTIFICATIONS F89 SNF (405.1121(j)) ICF (442.307) F90 1. The facility notifies the resident's attending physician and other responsible persons in the event of an accident involving the resident, or other significant change in the resident's physical, mental, or emotional status, or patient charges, billings, and related administrative matters.	Note resident's condition: Casts Bruises Decubiles Skin tears Multiple Ecema Aberrant behavior, e.g. abusive, disruptive, not reasonable, etc.	ASK RESIDENT - Have you been injured since you have been in the facility? - If you are injured or become ill, is your physician called? - Are your relatives notified? - Do you know who is notified if administrative changes such as changes in charges, bilings, etc. occur? ASK STAFF - Who do you notify if a resident is injured or has a change in condition? - When would they be notified? Does the facility have a policy regarding how soon a relative or responsible would be notified? - Do you notify them of actual changes in resident condition and also if resident's condition is getting progressively worse?	- Progress note should document injury/change in condition plus notification of physician and appropriate family member/guardian. - Changes in charges should be documented. Ask facility where this is located. - Review accident and incident reports for indepth sample.	- All injuries and changes in condition must be documented. The resident's physician and family must be notified of significant changes. This should be documented, but this notification should be confirmed by the resident if possible.	Resident Supervision by Physician 405.1123(b)(3) Emergency Services 405.1123(c)
F91 2. Except in a medical emergency, a resident is not transferred or discharged, nor is treatment altered		ASK RESIDENT - Have you ever been or do you know if others have been transferred or discharged without discussing it with you first?	- Nursing, physician and social work progress notes should be reviewed for evidence of discussion of transfer/discharge with resident or other designated person.	- Except in an emergency, all transfers or discharges are first discussed with the resident or next of kin as evidenced by documentation in the medical record or	

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radically, without consultation with the resident or, if the resident is incompetent, without prior notification of next of kin or sponsor. INTENT To assure that: -the resident receives proper treatment in the event of an accident or change of condition. -resident and/or next of kin or responsible party is aware in advance of any changes -resident is not discharged for payment reasons or facility convenience				confirmed by asking resident	

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PHYSICIAN'S SERVICES F92 SNF 405.1123 A. Medical Findings and Orders at Time Of Admission F93 SNF 405.1123(a) F94 1. There is made available to the facility prior to or at the time of admission, resident information which includes current medical findings diagnoses, and orders from a physician for immediate care of the resident. F95 2. Information about the rehabilitation potential of the resident and a summary of prior treatment are made available to the facility at the time of admission, or within 48 hours thereafter.		Ask Staff o Interview nursing staff to determine if they receive transfer information and admission orders on day of admission or within 48 hours of admission or all residents. o Ask Administrator and Director of Nursing to explain procedure if a resident arrives without sufficient medical information and/or orders.	Review records of residents selected for indepth review to ascertain that: o There is a referral form from the trarsferring facility that was received in advance of admission or on date of admission that includes current medical findings, diagnosis and orders from a physician for the immediate care of the residents. o If the medical orders were not obtained from the residents attending physician, there are temporary orders from the emergency care physician. o Information on the rehabilitation potential (prognosis) of the resident and a summary of the course of treatment followed in the transferring facility were transmitted within 48 hours of admission. o The summary of treatment should include discharge summaries from therapies or special services wher appropriate. o For residents admitted directly from the community, the attending physician provided current medical findings, diagnosis, prognosis, and orders. o The orders should cover: -Medications and Treatments -Diet -Therapies (P.T., O.T., Speech) -Activities (bedrest, ambulatory able to participate any specific limitations on activity)	Examine medical records of the residents selected for indepth review to determine if date of orders, medical data and other required information is the date of admission or within 48 hours of admission. The facility should receive sufficient information and orders to provide continuity of care for all residents.	

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RESIDENT SUPERVISION BY PHYSICIAN F96 SNF 405.1123(b) F97 ICF 442.346 B. Resident Supervision by Physician F98 1. Every resident must be under the supervision of a physician. F99 2. A physician prescribes a planned regimen of care based on a medical evaluation of each resident's immediate and long-term care needs. Not ICFs. F100 3. A physician is available to provide care in the absence of any resident's attending physician. Not ICFs. F101 4. Medical evaluation is done within 48 hours of admission unless done within 5 days prior to admission.	Observe resident for any problem/conditions that should be addressed by physician, e.g., edema, loss of appetite, weight loss, etc.	Ask Resident o How often physician visits. o If physician has discussed plan of care and medical treatment. o If resident feels treatment and plan of care meets his/her needs. Ask Staff o How often physician visits and is it often enough to meet resident's needs? o Does physician participate in evaluation and reevaluation of residents plan of care? o Does plan of care meet resident's needs? o Is physician available in an emergency? o Is physician available to discuss residents treatment and care? Ask Administrator o Facility's policy regarding a physician to provide care in the absence of the resident's own physician. o Facility's policy on physician visits.	Review medical records of residents selected for indepth review for: o A current plan of care that is based upon physician's owners and residents needs. o Evidence that the plan is reviewed and revised as needed. o Evidence through physician's progress notes, nurses notes, physician's orders, that the physician participates in the resident's overall plan of care. o Evidence that rehabilitation potential is addressed. o Long range plans include an estimate of the length of time for skilled nursing care and a discharge plan. o Physician's orders for medications and treatments on admission and during stay. o A medical evaluation completed within 48 hours of admission unless done within 5 days prior to admission that includes attention to needs such as diet, vision hearing, speech level of activitiy, emotional adjustment. o Evidence in care plans and treatment records that physician's orders are being implemented. o Discrepancies in medication record, diet order, intake and output records. o Evidnece that an alternate physician provided care if applicable. o Progress notes by physician at least every 30 days for first 90 days (ICF-at least every 60 days) o Review of medications and treatments every 30 days or 60 days if an alternate schedule of visits has been approved. o Documentation of physician observations, actions and plans for treatment. o Justification for alternate schedule of visits	Medical records should provide evidence that the residents are under the supervision of a physician by the coordination of physician's orders and progress notes with the resident's plan of care and observations of residents needs. There is evidence that the physician reviews and revises the plan of care as needed. There is evidence that physician services are available to the residents when the residents need such services. An alternate schedule for physician visits may be established if the attending physician determines that the patient need not be seen every 30 days. Justification for the decision is placed in the patient's medical record and is reviewed by the U.R. Committee and State medical review team. Where there is a change in patient's condition and the physician has failed to document his findings or evaluation of the condition, the physician has failed to provide evidence of his evaluating resident needs and supervising patient care.	

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EXCEPTION: Not required for ICF residents. F102 5. Each resident is seen by their attending physician at least once every 30 days for the first 90 days after admission. F103 Exception: ICF residents must be seen every 60 days unless otherwise justified and documented by the attending physician. F104 6. Each resident's total program of care including medications and treatments is reviewed during a visit by the attending physician at least once every 30 days for the first 90 days and revised as necessary. F105 Exception: Only medications must be reviewed quarterly for ICF residents.			A few closed records should be reviewed to determine if residents were appropriately discharged by an order written by the attending physician. Also review discharge plans to assure that they were adequate and implemented. Verbal medication orders are countersigned by a physician. MD is reviewing meds with quarter.	Although Medical evaluation can be noted as a revision of the previous MEF a statement such as "no charge" when in conflict with the status of the resident at admission to the facility, does not constitute a Medical evaluation Verbal medication orders must be countersigned within 48 hrs.	

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F106 7. Progress notes are written and signed by the physician at the time of each visit, and all orders are signed by the physician. Exception: Not required for ICF residents					
F107 8. Alternate physician visit schedules that exceed a 30-day schedule adopted after the 90th day following admission are justified by the attending physician in the medical record. These visits cannot exceed 60 days or apply to patients who require specialized rehabilitation schedules. F108 Exception: ICF residents must be seen every 60 days unless justified otherwise and documented by the attending physician					

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C. Emergency Services F109 SNF 405.1123(c) F110 Emergency services from a physician are available and provided to each resident who requires emergency care. INTENT: To assure that a physician has overall responsibility for the management and supervision of the residents care		Ask Staff o Are you aware of procedures to be followed during an emergency? o Do you know where names and telephone numbers are of physicians to be called in case of emergency?	o If records document an accident or a medical emergency, was the patient seen by a physician or was the physician notified promptly of the emergency? o Review physician's orders to see if specific medications or treatments were ordered to treat emergency situation if applicable? o Review physicians progress notes to see if emergency situation was addressed.	o Surveyor verifies that there are readily available written procedures for securing a physician in case of emergency. o Names and telephone numbers are posted or on rolodex. o An alternate physician is designated. o There is provision for: -Notification of attending physician/emergency and other responsible person. -Arrangements for transportation. -Preparation of reports. -There is evidence in the medical records that proper procedures have been carried out. -Residents with sudden changes in condition have been evaluated by the physician.	Status Change Notification 405.1121 (j)

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Nursing Services F111 SNF 405.1124 F112 ICF 442.338					
F113 SNF 405.1124(c) ICF 442.338 A facility provides nursing services sufficient to meet nursing needs of all residents all hours of each day. F115 Grooming and Personal Hygiene SNF 405.1124 (c)	Basic care provided to residents: Surveyors should observe the basic care provided by staff to the residents. Listed below are suggested areas of attention which may provide evidence of the quality of personal care: o Eyes/Ears/Mouth Presence/absence of: -- Secretions forming around eyelids, redness or irritation of eyes. -- Backs of ears scaly, obvious wax build-up, discharge, odor. -- Dried food particles or drool, etc. around mouth. -- Dentures worn when appropriate -- Oral hygiene o Odors Presence/absence of: -- Body odors, deter- o Hair/Scalp -- Clean -- Hair combed	Suggested interview questions include the following: o If the resident's clothing is inappropriate, ask: - Did you choose your clothing today?able. - Is this what you want to wear? - Do you have other clothing available? o If the resident is not clean, poorly groomed, or inappropriately groomed, ask the resident: - Have you had any help in caring for yourself today? e.g., washing your face, brushing your teeth, etc. - How often do you have a bath/shower? - How often is your hair washed? - How often do you brush your teeth/ clean your dentures? o Special consideration might be given to the demented patient who frequently "borrows" clothes and for whom	Nursing notes should indicate that the care plan for grooming and personal hygiene is being followed. For example: o Bathing schedules are being followed (including the use of any special lotions or soaps). o Assistance instruction and/or supervision is being provided as identified for each activity. Nursing documentation should also indicate resident response or any changes in the resident's behavior, reaction to an activity, or the ability to carry out grooming and personal hygiene activities. Look for indications of progress toward a goal or further deterioration of resident functioning.	Refer to information on observation. A pattern of evidence of poor personal care indicates noncompliance unless the care plan specifically deals with this and appropriate planning and implementation is occurring. The regulations require that individual preferences are taken into account when providing for grooming and personal hygiene and that residents are encouraged in self-care activity. Do your patient interviews substantiate compliance with the regulations?	Resident Rights 405.1121(k)(q)(13) 442.311(g)(k) Social Services 405.1130(a) 442.344 Activities 405.1131 442.345(a)(c) Patient Care Management 405.1124(d) 442.341 Training 405.1121h 442.314

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Wounds/Wound Dressings F114 SNF 405.1124(c)	o Condition of dressing - i.e. clean, firmly secured unless contra-indicated o Observe, if possible, and with resident's permission, a dressing change - Pre-dressing Removal Equipment and supplies organized Hands washed Resident provided with privacy - Dressing Is: o Old dressing observed for drainage? o Wound examined o Appropriate technique used o Proper disposal of old dressing? o Post dressing o Does staff member wash hands? o Return resident to comfortable position or previous activity?	Ask resident: o How often is the dressing changed? o By whom? o Does it seem often enough? o Are there any odors from it? o Is the change always done in a similar way? o If not, what are the differences? o Do you feel confident that the wound is being well cared for? o Is the area/wound healing? o What caused the ulcer, wound, etc.? Is it healing? Does the staff keep you informed of its status? Ask staff: o Specific treatment and schedule for each resident	o MD orders for wound care o Progress notes detailing condition of wound - i.e. size, drainage, surrounding tissue, odor o Treatment provided o Progress/change o Plan of Care - The plan of care should address: o Area in need of treatment, treatment to be performed, frequency, and responsible staff. o All necessary solutions, ointments, irrigations, types of dressings, and materials. o Any necessary precautions, drains, if present, sutures and tubing o Specific goals of treatment as well as any problems or limitations imposed as a result of treatment.	MD orders, your observation, progress notes and P.O.C. should reflect the same information. Treatment provided over a period of time with no improvement and no re-evaluation also would represent non-compliance, unless nursing physician progress notes address the "no improvement" problem. Compliance is evidenced by: o treatment given according to doctor's orders and plan of care o use of appropriate technique when caring for wound/changing dressing o Periodic evaluation of healing process and revision of care as needed.	Physician Services 405.1123 442.346 Infection Control 405.1135(b) Pt. Care Management 405.1124 442.341 Dietetic Services 405.1125(b)(c)(e) 442 332(a)(1)(b)(1) Medical Records 405.1132 442.318

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	- Extremities elevated as necessary while in chair or wheelchair. - Appropriate techniques to prevent infection. - Use of whirlpool as a treatment modality as available and appropriate. o With resident's permission check: - heels - lateral hip - scapular area - sacrum - buttocks - bony prominences in contact with braces - condition of stump (especially diabetic amputees with elastic bandage or sock removed)	removal may elicit catastrophic reaction-whether clothing "matches" may not be the most important issue in the care of these patients. Ask direct care staff: - How do you choose what clothing each of your residents wear each day? - Do you have a specific schedule for washing residents' hair? - How did you learn to bathe residents? - How do you handle situations when residents want to wear dirty clothes, or mismatched clothes? - How much care do you let the residents do on their own?	Physician order for use of		
Skin Condition SNF 405.1124 (c) F116-117	Observe with residents' permission: o General condition of skin - soft/dry/rough etc. - Rashes/irritation - Bruises - Scabs - Free of above o Measures taken to pre-	Ask Resident: o Are your feet usually swollen? o Do you know what causes the swelling? o What do you do to alleviate it? o Is this discoloration normal for you?	Look at nursing notes and P.O.C. for evidence of o Planned preventive measures o Treatments/Intervention, including nutrition o Routine assessment/evaluation of skin condition	Preventable decubitus ulcers are not occuring Ulcers present are treated on a routine basis according to P.O.C. Is skin clean? Is resident dry? Is turning schedule adhered to? -	Dietetic Services 405.1125([illegible])(c)(e) 442.332(a)(1)(b)(1) Activities 405.1131([illegible]) 442.345(a

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SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
	vent skin breakdown. o Decubite o Rx of decubite o Factors contributing to prevention of decubitis ulcers - Overall cleanliness and maintenance of dry and aerated skin (uncompromised by urine/feces/perspiration) - Padding for pressure points and bony prominences including padding on bed/chair - Proper gentle massage to bony areas several times a day. - Regular assistance for resident to turn or shift weight (bed-rails, footboards, trapeze). - Bed linens, clothing, underpads smooth and free from wrinkles. - Elastic bandages or hose smooth and wrinkle free - Elastic bandages wrapped smooth and crisscrossed. - Dietary/nutritional support for skin integrity. (See Guidelines for Dietary/Nutrition.)	o How did this wound/bruise develop? o Are the treaments done about the same time every day? o What staff person has looked at your skin recently? o Assessment/Reevaluation of interventions with alterations in plan o Appropriate nutritional plan o Methods to control edema of lower extremities Ask direct care staff: o What can you tell me about Mr./Mrs. _____ swollen feet/wounds/bruises/etc. o What do you do for them? Ask charge nurse: o How did _____ get cuts, bruises, etc? o What is being done to prevent further occurrance? o What treatment is he/she receiving	o Documentation of specific skin problems with location number, severity, measurements as appropriate, and cause o Progress or lack of progress in healing	Are linens clean and smooth? Do personnel know preventive measures and practice these? Has a nutritional assessment been done, and if appropriate, recommendations implemented?	Patient Care Management 405.1124(d) 442.341 Training 405.1121(h) 442.314 Rehabilitative Nursing 405.1124(e) 442.342 Supervision of Patient Nutrition 405.1124(f) 442.332(b)(2) Resident Supervision by Physician 405.1123(b)

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SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
	- Prevention of shearing force when resident's position altered by staff. - Turning and repositioning as needed. o Care and Treatment: - Turning and repositioning every two hours or as needed. - Positioning off the ulcer site or protection of affected areas.				

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Restraints F118 SNF 405.1124(c) When residents require restraints the application is ordered by the physician, applied properly, & released at least every two hours. (see also information under Resident rights-freedom from abuse & restraint.	Direct to evidence of: o Proper application o Proper use o Maintenance of good body alignment o Resident observation, release and exercise Observe frequently throughout your visit to validate care. Specific observations should include the following items: o Type of restraint: posey belts, wrist or ankle cuffs, blanket restraints, vests, bed nets, etc., as well as geriatric chair (or geri-table in place for prolonged periods). o Appropriate application: skin protected from injury (restraint neither too loose nor too tight to prevent rubbing and blistering or impeded circulation). o Body alignment and support: use of pillows footboards, and wheelchair footrests to maintain appropriate posture, circulation, and to prevent skin injury or breakdown.	Because the use of restraints may be precipitated by an "emergency" situation in which there is a threat to the resident's health or safety, or a threat to the health and safety of others due to the resident's behavior, restrained residents may not be coherent or rational enough to respond to questions. Caution in interviewing therefore, must be exercised. However, observation of a resident in a geri-chair with table in place or a resident in a wheelchair (with vest restraint) for several hours would warrant an appropriate questions as to when the staff last assisted him or her to move about or whether the resident would like to get out of the chair. Staff interviews focus on the reason why the resident is restrained. Ask Direct Care Staff and Charge Nurse:and how to o When, why, and how to release and apply restraints. o Why is the resident restrained? o Was the resident given an option of restraint? o When were you taught	o MD Orders for restraint: reason, length of time, type o Progress notes o Describe the resident's status/behavior which prompted the use of the restraint. o If a chemical restraint, the order should indicate a specific time period for its use as well as a stop date. o Plan of Care The plan of care should: o Identify other methods or therapies that are being used in conjunction with restraints to modify or control behavior. o Identify staff responsible for observing the resident (every 30 minutes), and releasing and exercising him/her (every 2 hours for at least 10 minutes). Time intervals should be identified. o Indicate involvement and input of other disciplines necessary to overcome the problem. o Indicate a specific period of time for using the restraint (e.g. orders not enforced for longer than 12 hours, unless resident condition warrants)	o Is there a physician's order, including the circumstances in which they will be used, the length of use, and the type of restraint? o Is the restraint applied properly? o Is it released at least every two hours and the resident provided with exercise and toilet facilities if needed? o Does the staff observe the resident frequently while he/she is restrained? o Are chemical restraints administered in accordance with physician's orders? o Is the order for restraints renewed only after a reassessment of the patient?	

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	o Periodic release and exercise: exercise may include ambulation, range of motion, massage, or other opportunities for motion (at least 10 minutes every 2 hours). o Chemical restraints: residents appear drowsy and unresponsive throughout the day (may indicate tranquilizers or other drugs are being used to limit or control behavior for staff convenience).	about restraints? By whom? o What are your opportunities for retraining? o If chemically restrained (excessively sedated) - why this is done - whether alternate means of restraint have been attempted, for how long this will continue, etc. This should elucidate from staff whether the chemical restraint is necessary, or whether it is done for staff convenience by controlling resident behavior Ask Resident: o Suggested questions are: - Why are you restrained? - How often do you wear the restraint? - What would happen if the restraint were removed? - Were you given any other options? o When do you use bed rails? o What purpose do they serve? o Do you ask the resident for permission before using them?	o Indication of assessment of factors which precipitate residents behavior which has warrented restraints & plans to intervene early enough to prevent occurrence. o Physician notified of abnormal lab values.		

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Bowel and Bladder F119 SNF 405.1124(c) Each resident with incontinence is provided with care necessary to encourage continence including frequent toileting and opportunities for rehabilitative training.	o There should be a chart/record in the resident's room on which the program is documented accurately. o If the room is located a distance from the toileting room or for residents with problems ambulating, a commode may be present in the room. o Verify that a call light is available to the resident if non-ambulatory or restrained. o Are fluids at beside, roughage on tray	Both the resident and direct care staff should be interviewed and should exhibit a good understanding of the importance of maintaining a regular schedule of elimination. If neither are aware of the intake and toileting schedule, then question whether they are simply panning the resident rather than carrying out a retraining program. o Verify that the resident is aware that he/she is on a retraining program and the content of the program. Ask Resident: Suggested questions are: o How do you deal with constipation/diarrhea? o Are you involved in a special bowel/bladder training program? o If so, how does your program work? o Any problems with it? Any successes to date? o What does the staff do for you in this matter? o Are they consistent and timely? o How long do you have to wait to be taken to the toilet?	o MD Orders if required by facility policy o Nursing notes for - Assessment - Documentation of techniques and progress, reevaluation o Plan of Care The plan of care should clearly address: - Goals that resident will aim for. - Methods to accomplish the goals. - Schedule for fluid intake. - Schedule for toileting. - Responsible staff - Any limitations the resident may encounter as a result of either incontinence or the training program. o Progress notes/MD orders for shifts assessment or cause of incontinence. o Laboratory tests of kidney function o Treatment for diarrhea/constipation o I & O o Pts. preference for treatment for constipation. o Recently admitted and newly incontinent residents should be thoroughly assessed for the cause of incontinence and an intensive bowel	o Are all incontinent patients assessed for cause of incontinence and ability to be helped by a bowel/bladder rehabilitative training program? o Are all appropriate residents involved in bladder/bowel training programs or is there a schedule that shows when the program will be started? o Is there evidence of follow through on all shifts? o For residents not on bowel/bladder retraining programs the plan of care should address specific measures for managing incontinence with a view to prevention of skin and other problems and maintenance of resident dignity.	Nursing Services 405.1124(e) Dietetic Services 405.1125(c)

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	o When a resident puts on his/her call bell for toileting assistance, how long is it before assistance is given? o Observe pre-meal toileting. o Privacy provided.	o Ask nurses aides & charge nurse: - Will you describe this resident's bowel/bladder training program? - How long has it been in effect? - When will you evaluate the results? - If this program is not successful o What assessment was done to determine B&B status o For residents not on bowel/bladder retraining programs, what in your overall program for managing incontenence?	and bladder training program should be instituted when appropriate.		
Catheter Care F120 SNF 405.1124(c) Each resident with a urinary catheter receives proper routine care including periodic evaluation	The indwelling Foley catheter should promote a continuous flow of urine unless ordered otherwise. The surveyor should also observe for the following: o Ample supplies for catheter insertion and care. o Proper positioning of the tubing and drainage bag. o Cleanliness of the tubing and drainage bag.	Ask Resident: o What is the tubing/catheter for? o Why do you have one? o Does it cause any discomfort? o If it does, what is done about it? o How do you feel about having the catheter? o Is any special care given in relation to the catheter? Ask nursing aide & charge nurse:	The surveyor should verify that there is a physicians order for an indwelling catheter, including the type and frequency of catheter care. If irrigation is ordered, the order should include type of solution and frequency of irrigation. The record should also indicate the color, consistency, and amount of urinary drainage. o Assessment should address:	*The facility should follow accepted professional standards in their catheter care. There should be medical reasons for catheter insetion - staff convenience cannot be justified. Direct care staff should know signs and symptoms of U.T.I.'s and these should be reported and treated promptly.	Infection Control 405.1135(b)

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	o Color and consistency of urine in bag. o Availability and accuracy of documentation on the I&O sheet if ordered or policy. o Proper equipment for ambulation - leg bag if resident is ambulating. (if ordered) o Availability of fluids. o Monitoring of fluid intake to ensure adequate intake and/or conformance with physician orders.	o How do you routinely position secure catheters and drainage bags o How often is each part of the system changed? o What are the indications for insertion of the catheter? o What is the facility's procedure for routine catheter care? o How do you observe for U.T.I's in residents with Foley catheters?	- Need for an indwelling catheter. - Resultant problems or limitations o Plan of Care The plan of care should address: - Type of catheter and type and frequency of care. - For irrigation, the rationale, the type of solution, amount, and frequency of irrigation. - Frequency of symptoms which would precipitate catheter change. - Time frames of catheter change and responsible staff. - Appropriate increase in oral fluid intake. o Intervention The record must reflect: - When and by whom the catheter was inserted and for what reason. - Any special care provided - New problems or changes - Only appropriately trained staff should deliver catheter care. - Licensed staff only should insert	*The Center for Disease Control has developed standards for catheter care but it is not required that these standards be used.	

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Injections F121 SNF 1124(c)	o Observe for preparation of injection - i.e maintenence of sterility; correct dilution, handwashing, before preparation, etc. o Observe injection site for: - Redness - Discoloration - Swelling - Lesions o Observe for proper technique when injection is given - correct site - correct nedle size - correct volume of drug - sterility maintained o Resident is observed for any adverse reaction o What is the disposal method for used needles or syringes?	Ask Nurse: What is your plan for alternating injection sites? Show me. o What is the medication for and what are potential adverse reactions? o Is there nonspecific pain at the injection site or shooting pains down a limb? o Is there skin irritations or lumps under the skin? o Of adverse reaction occur, how soon are they reported? o Could this be given by any other route? Ask Resident: Suggested questions are: 1. What kind of medicine do you receive by injection/shot? Why do you need that medicine? 2. Do you have pain or numbness at or around your injection site? 3. Who gives you the injection? 4. Do you receive your injection according to a schedule?	o MD order sheet o Nursing notes for: - Resident response to medication if appropriate - Any problems noted at injection site - Any other adverse reactions - Site of injection o Plan of care - Rotation of injection site - Care for any special problems related to the injection. o Infection Control: reports for any infections connected with injections.	o Is the medication administered according to the physicians order? o Is proper technique used in preparation and administration including site rotation? o Does the nurse administering the medication know the expected action of the drug? o If infection control reports show infections at injection sites, are they caused by improper administration? o Is the patient's response to the medication noted in the progress notes?	Staff Development 405.1121(h) 442. 314 Infection Control 405.11 35(b)

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Parenteral Fluids F121 SNF 405.1124(c)	The surveyor should observe that parenteral fluids are administered with safe, aeseptic technique providing fluids as ordered by the physician. Safety and comfort measures are to be taken insuring maximum protection and optimum hydration of the resident. The surveyor should note the following items: o Labeling of the solution bottle/bag. o Rate of infusion/hour. o Date and time started --additives, if any. o Any signes of swelling or redness at site. o Site dressing is clean and dry. o Accurate I&O of parental and P.O. fluids. o If splint (armboard) is used, it is applied to prevent movement but not impede circulation. o Positioning of IV tubing o Comfort of restraint used to allow for maximum resident freedom while preventing movement of IV site.	Ask resident: o Why do you have this tube in your (arm)(leg) o Is it comfortable? o Is there a way it would be more comfortable? o How long has it been in? o How much longer will it stay in? Ask appropriate staff: o Why the resident is receiving IV therapy o What the drip rate is The amount of fluid to be received per hour o How often the dressing is changed o How often the tubing is changed o What are possible side effects? Ask Nursing Aide: o What are your responsibilities when care for a resident receiving IV fluids? o What training have you had?	o Physician's order for parental therapy specifying type of fluid, rate of infusion/hour, and additives, if any, is available and current. o Twenty-four hour I&O record. o Nursing documentation indicates physician's orders are being followed. o Any adverse reactions are noted in the medical record. o Record indicates: - The need or reason for parenteral fluids. - Response to the therapy. - Problems and limitations encountered by the resident as a result receiving parenteral fluids. o Plan of Care* The plan of care shoulo include - Type, rate of infusion/hour, and additives (if ordered). - Frequency of site dressing change and tubing change. - Mouth care, if NPO - Identified problems or limitations, including specified	o Is the parenteral fluid administered according to the physician's order and in accordance with accepted nursing practice? o Are infiltrations noted in a timely manner before a large amount of fluid infiltrates? o Is the facility procedure for care of the IV site and tubing changes followed for all patients unless contraindicated? o Does documentation reflect what the patient received, any problems, and his/her response to the parenteral fluid? o Have any adverse effects been caused by administration of IV fluid? o If yes, were these preventable?	Resident Care Policies 405.1121(1) Infection Control 405.1135(b) Pt. Care Management 405.1124(d) 442.341

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			specified goals for correction, time frames, and responsible staff. o Documentation must include time administered and by whom, the amount of fluid infused, and any other special care administered as a result of IV therapy (i.e., mouth care, assistance with ADLs, etc.). o The record must reflect: - conditions of site and any infiltrations, phlebitis, necrosis, etc. noted, along with measures taken to correct these. - The resident's response to therapy - Changes in laboratory studies *Plan of care would not be modified for a one-time IV infusion.		

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			catheters. - The specific type and size of equipment used should be noted. - Signs and symptoms of urinary tract infection (UTI) should be acted upon and documented as to follow-up. o Evaluation/Reevaluation The record should reflect that the resident: - Is assessed for UTI - Has no abdominal distention. o Notes should also include: - The color and odor of urine and the development of any problems after Foley insertion.		
Colostomy/Ileostomy F121 SNF 405.1124(c)	The surveyor should ascertain that the facility is providing appropriate nursing care to those residents who have had bowel surgery resulting in a colostomy or ileostomy. It is recommended that the surveyor, with the residents permission, observe care being given to determine that proper tech-	Ask Resident: o Why was the ostomy performed? o How do you feel about the ostomy? o Does it ever cause you problems (i.e., pain, skin problems, odors accidents?) If so, what does staff do about it? o What does the staff generally do with or for	The surveyor should determine that: o Colostomy irrigations, if ordered, are documented as performed by the resident or appropriately trained staff. o Regular patterns of bowel elimination are documented as established through management of diet, fluid in-	Compliance would be indicated if residents are physically and emotionally comfortable with the ostomy with minimal or no skin problems. If residents are not comfortable with the ostomy, are having skin or other problems, the facility should be responding to these and correcting them as reasonable. Care	Patient Care Management 405.1124(d)

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	niques are being used. The following steps should be taken to assure that proper ostomy care is being provided. o The ostomy dressing should be changed or the bag emptied and thoroughly cleaned promptly after each bowel evacuation or more frequently, if drainage continues. o The peristomial skin should be cleansed and dried, and appropriate measures taken to prevent excoriation and infection. o The resident's privacy should be considered while providing care. o The resident should be provided with information and instruction in self-care at the appropriate level of understanding. o The resident should be observed for signs of withdrawl, disgust, anxiety, or other emotional responses which may be related to his/her acceptance of the colostomy/ileostomy.	the ostomy? Are they consistent and timely? o Has staff talked to you about doing some of the care for this? If so, what was the outcome? If not, is this something you'd be interested in learning more about? Ask Staff: o If nurses aide: - How did you learn to take care of colostomies? - What do you do if the skin around the colostomy becomes red or sore? - Do you ever teach the residents to care for their own colostomies? - What is the procedure if the resident becomes constipated? Ask other nursing staff: - Is there a facility procedure for ostomy care? Do you have skin problems with your ostomy residents? - What do you do when	take, exercise, and the use of prescribed laxatives, suppositories, and/or irrigations. o Ostomy care is documented in the resident's record along with a description of the stool. o Problems in irregularity, skin breakdown, or other observable concerns are documented and reported to the physician. o Documentation indicates that nursing measures are taken to assist the resident who is experiencing problems in understanding and/or accepting the presence of the colostomy/ileostomy. o Documentation of nursing measures to maintain skin integrity. o Assessment The assessment should indicate: - Needs, problems, and limitations as a result of a colostomy/ileostomy. - Specific degree of self-care performed or assistance needed. - Special skin care	plans should indicate specific goals in relation to problems and specific interventions for reaching these goals.	

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	o The surveyor should observe the staff giving ostomy care to verify that proper technique is used.	skin becomes excoreated? - What teaching do you do with the residents? - What in general is the response to this teaching?	needs. - Regulation and special dietary needs. - Emotional support. - Medications and treatments if needed. o Plan of Care The plan of care should clearly address: - Specific goals to overcome or improve the problem(s) identified. - Methods to accomplish the goal (training, assistance, supervision, treatments, emotional support). - Services necessary and who will perform the services. - Time frame for accomplishing goals.		Social Services 405.1130(a) 442.334(a)(b)

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
F121 Respiratory Therapy SNF 405.1124(c)	o Aerosol Compressor or IPPB (Intermittent Positive Pressure Breathing Machine) The surveyor must determine that the facility is providing respiratory therapy as ordered by the physician. Observation for this indicator should focus on the necessary equipment as well as on the resident. In order to determine that the necessary equipment is available, the surveyor must look for the following: - Aerosol compressor or IPPB Machine. Check that the machine is clean and operable. - Tubing - If tubing is not attached to the machine, ask to see it. Check that it is stored dry and with consideration for cleanliness. - Nebulizer Cup - should be attached to tubing. It is filled with either the prescribed medicine or distilled water only if about to be used. It should not be stored wet. If it is not attached to the	While interviewing the resident, observe for sounds of congestion. Note color of lips and nail beds. Ask Resident: o Do you ever feel short of breath? o If yes, what is done when this occurs? o Is the therapy helping you to feel better? o Are there any problems with it? o If so, how does the staff respond? o Is the therapy consistenly performed - both concerning time and method of providing it. o Do you have any concerns about the therapy? Ask Staff: o What is the reason the resident is getting this therapy. o What are the expected results? o Can you demonstrate how you use the equipment? o How often is the equipment cleaned? o What are the infection control procedures in	The surveyor should determine that: o Respiratory/oxygen therapy is performed or administered by appropriately trained staff. o There is a physician's order for therapy, and it is specific as to rate of delivery, etc. o If the physician's order is for prn therapy, it should specify for what symptoms. o Any information gained from resident or staff is verified in the record. o Assessment - The assessment should address both the need or reason for therapy and any problems or limitations which result from the need for therapy. o Plan of Care The surveyor should note: - The kind, amount, frequency, and/or duration of therapy based on the physician's order. - Specific goals to overcome to improve any identified problems and/or limitations.	Only qualified (trained) personnel should administer/assist with respiratory therapy. Therapy must be provided as ordered. The effectiveness of the therapy must be periodically evaluated and therapy revised as appropriate. Effective infection control measures must be practiced. Needed safety precaution for the use of oxygen must be practiced. Equipment should be available and in working order.	Staff Development 405.1121 (h) 442.314 Infection Control 405.1135(b) Patient Care Management 405.1124(d) 442.341

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	tubing, ask to see it. The mouthpiece is connected to the nebulizer cup. The surveyor should also check that all involved equipment is clean. o Oxygen Therapy The surveyor must establish that the facility is meeting the oxygen needs of the resident. When the facility does not have wall units, check that: - There are enough cylinders for oxygen delivery. - There should be at least as many flow meters and regulators. - A wrench should be attached or stored close by. - If using large cylinders (size G or H), look for a carrier since these tanks cannot be transported without it. - The cylinder at the resident's bedside should either be on the carrier, sitting on a metal skirt, or otherwise secured. - There should be other	regard to use of respiratory equipment? o What training was given you in the use of this equipment? o Where is the emergency oxygen supply?	- Specific methods to accomplish the goals (observation, supervision, training, etc.). - Who is responsible to perform therapy or assist in accomplishment of goal. o Intervention - The record should display evidence that: - The plan of care is functional - The therapy was admin- administered in accordance with physician's order for the specified reason(s) by an appropriately trained staff member - Change in condition is tion is documented and acted upon promptly. o Evaluation/Reevaluation The record should reflect: - The resident's response to therapy. - If response was undesirable, evidence of further intervention. - Any progress, deterioration, or development of new problems. - Based on the above information, possible modification of goals.		Physical Envionme 405.1134 (i) Medical Records 405.1132 442.318

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	necessary equipment available such as humidifiers, nebulizers, masks, nasal cannulas, T-pieces, etc. all should be dry and clean when stored. - Check to see that non bed bound residents are not limited to or own chair/room when using oxygen (portable units will prevent social isolation. - Check to make certain the tank is not empty and that any tank is labeled as such. - Check for good oral hygiene of resident. - The room should be posted with a "No Smking" sign.				
	o Residents on respirators: - Are alram systems turned on? - Is sufficient Oxygen supply available? - Is the ventilator plugged into an emergency outlet? - Is the resident in a location that allows for frequent observation by staff? - How does the resident communicate with	Residents on Respirators Ask Staff (all levels): o What training have you had in caring for residents on respirators? o Can you show me how the alarm system works? o What is your procedure for pulmonary care? o What is your procedure for changing tubing and the water resevoir? o What happens if the power goes off?			

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	staff? - What level of staff (aide, LPN, RN) caring for the resident? - Is such equipment at bedside? - What is the condition of the residents skin around intubation tube/tracheostomy. - Does the care given use appropriate technique in caring of the patient?				
F121 Tracheostomy Care SNF 405.1124(c)	Satisfactory tracheostomy care is a procedure which promotes a clean, unobstructed air passageway and maintains the skin integrity surrounding the tracheostomy site. The surveyor should determine whether: o Adequate supplies are available for the care of the tracheostomy such as tracheostomy kits, hydrogen peroxide, normal saline or sterile water, suction machine, catheter, sterile gloves, and clean dressings. o The resident is	Resident interviews must be guided by the resident's communication ability. Ask Resident: o Why do you have this tube? o How long will you have it? o What care can you do for yourself? o What do you need help with? o Who helps you? o Is someone always available to suction him/her when needed? o Is the suction equipment always available in working order? o Is the dressing kept	o The surveyor should determine that tracheostomy care is done as scheduled and as needed following the proper procedure. o Any special solutions that are needed should be addressed in the physician's orders. o Assessment - The record should reflect that the need for tracheostomy care was assessed in terms of: - Frequency - Skin integrity surrounding the tracheostomy, noting redness, inflammation, and/or excoriations. o Plan of Care should	Stoma and surrounding skin should be in good condition and if not, there should be treatment directed to resolving this problem. All staff caring for the tracheostomy must be trained and emergency procedures must be known. All needed equipment must be available and in working order. Resident must at all times have readily available a means of communicating with the staff in an emergency	Infection Control 405.1135 (b) Training 405.1121(h) 442.314 Patient Care Management 405.1124(d) Physicians Servic 1105 1123(h) Social Services 405.1130(a)

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	breathing without difficulty and is comfortable. o The dressing is clean, dry, and intact; the cannula is clean, in the proper position, and secured. o The skin surrounding trach is clean and dry with no redness or inflammation. o The resident has adequate oral hygiene. o An extra tube, the same size as the one in place, is available at bedside. o Does resident have an adequate method of communicating with the staff? o Does staff allow enough time for residents to communicate?	clean and comfortable? o Is the tube kept clean and changed as needed? o How often are the tubes and dressings changed? o Does he/she feel confidence in the personnel caring for his trach- o What is communicating with staff and other residents like? o Are staff patient and do they allow you enough time to express your needs/thoughts/feelings. Ask Staff: o Why does resident have tracheostomy? o What training were you given to enable you to care for tracheostomies? o What is the procedure for tracheostomy care? o How often is the tube changed? o What do you do if the tube comes out? o May I watch you do a dressing change? o If not convenient, describe what you do.	include: - Specific times of trach care and the responsible, appropriate trained person performing this task. - Specific problems relating to skin and breathing as well as the goals set to overcome these problems listing the appropriate personnel responsible. - Time frames for resolving problems listed in goals. - Plan for period assessment of appropriateness of residents own self care re: teaching or nursing assuming more responsibility as appropriate. o Intervention - The surveyor should look for documentation of: - Trach care and oral hygiene administration, including responsible personnel, time and date, and effects. - Any problems or changes noted in resident condition (e.g., redness, swelling, tracheal obstruction).		

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			- Emotional response to tracheostomy. o Evaluation/Reevaluation - Resident is or is not benefiting from trach car and skin care. - If problems are noted, the progress notes and plans for care should indicate changes in treatment. - Resident's emotional response to care of the tracheostomy should be evaluated, since this may require additional care planning		
F121 Suctioning SNF 405.1124(c)	Suctioning is necessary for any resident who is unable to cough up secretions that are obstructing his airway. Suctioning may occur via the oral or nasal route, or stoma route with sterile technique. Attempts should be made to observe a resident being suctioned should such an opportunity arise. If so, observe that a clean/aseptic technique is observed throughout and that the resident tolerated the procedure. There should	Ask Resident: o How are you feeling now after the suctioning? Does the suctioning seem to help? o Has staff explained to you the need for suctioning? Why do you need to be suctioned? How often? o Who performs the suctioning (i.e., nurses or nurses aides)? Do you feel safe with the staff performing the suctioning? o Does everyone do it about the same way?	o Assessment - The record should reflect that: - The resident is constantly observed for suctioning needs. - Any limitations a resident has as a result of his suctioniong needs should be specifically noted. - Any problems resulting must be specified. o Plan of Care should include: - Awareness of the resident's suctioning needs, goals, approaches, and responsible staff	o All equipment must be available and in working order. o All staff caring for the resident must know what to do in an emergency. o Current professionally accepted standards of care must be maintained	Infection Control 405.1135(b)

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	not be bloody aspirant, cyanosis, or bronchospasm. Check that equipment is in good working order, frequency of procedure, etc. Resident observations which indicate need for intervention include: o Secretions are draining from a resident's mouth or trach and the resident is unable to cough or clear himself. o There are audible crackles or wheezes and/or diminished breath sounds. o The resident is dysepneic. o Restlessness or agitation may also be an indication that suctioning is needed. Upon completion of suctioning above symptoms should, in most cases, be relieved. The surveyor should observe that the resident is positioned to facilitate breathing (usually at a 45 degree angle). Check to see that the facility has an ample supply of suction machines and suction catheters	Ask Staff: o When and where did you learn to suction? o Tell me what procedure you use when you suction a resident. o Do you always have enough suction machines and catheters? o What provisions do you have for suctioning if the electricity is lost? o Where are you emergency electrical outlets? o What is your emergency procedure for disposing of the secretions from suctioning? o How often does Mrs./Mr. need to be suctioned? o May I observe you when you suction Mrs./Mr.	needed to improve the problem or at least to maintain the resident at his present status without further deterioration. - The plan must clearly indicate specific approaches towards: o Prevention of skin problems around the trach if one exists. o Correction of any existing skin problems. o Provision of good oral hygiene including a rigid schedule for mouth care, schedules, or procedures for maintaining clean equipment at bedside, as well as disposal of used (dirty) equipment. o Route of suctioning (i.e., oral/nasal/trach). o Intervention - The record should indicate clearly that: - The plan of care is being implemented. Documentation should reflect: - The number of times the resi-		Patient Care Management 405.1124(d)

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	to meet the needs of residents requiring them and that they are clean and properly stored.		required suctioning, for what specific reason, and by whom the resident was suctioned. - Any special treatment the resident received in conjunction with suctioning (i.e., oral hygiene, skin care, etc.). o Evaluation/Reevaluation The record should reflect: - How well the resident tolerates suctioning procedures. - Any bloody aspirant, cardiac arrhythmia, cyanosis, or bronchospasm. - Further interventions utilized to overcome or improve these. - The amount of sputum as well as its color and consistency. - Any progress or lack of progress, deterioration, and/or the development of new problems. - The evaluation should determine whether goals are being reached or if new goals must be addressed.		

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Tube Feedings F121 SNF 405.1124(e)	o Staff use proper technique in administering feedings and medications. Check to see that staff checks for location of tube before feeding and that tubing is irrigated before and after addition of medication. o The tube is clean and formula flows freely. o The equipment is clean and protected. If dressings are ordered, they are in place, clean, and dry. o The nasal tube is securely but comfortably secured on the face with skin maintained intact and without irritation. o The skin around the gastrostomy is kept clean and free from irritation or infection. It should be checked carefully for leakage of gastric contents. o A resident who has a N/G tube for a prolonged period of time should be observed for possible complications, such as nasal erosion, sinusitis, esophagitis, gastric ulceration, and pulmonary infection.	If the resident is able to be interviewed, suggested questions may be: Do you feel comfortable/safe with all the staff who perform the feeding? If not, what happens? Are you losing or gaining weight? What is your goal?	Tube Feeding Review: - Plan of care - Identify frequency, amt of feeding based on the physician's order and time span over which each feeding is accomplished. - Medication and treatment records - Fluid intake records - Number of calories as well as amount of additional water - Documentation present regarding removal and reinsertion of tubes - Record should indicate measures taken to prevent diarrhea and constipation and to treat if they have developed.	o Has the feeding been ordered by Physician? o Is tube feeding nutritionally adequate? o Have attempts been made to discontinue tube feeding if indicated? o Is skin free from irritation; mouth care is given at least (3) times daily? o Have changes in resident condition been noted and addressed (weight loss, constipation, diarrhea, skin condition)? o Have observed problems been coordinated with other departments and resolved? o Is feeding being monitored to ensure that feeding is occurring at the ordered/appropriate rate? o Varied supplements as preferences allow?	Nursing Services 405.1124(d)(f) 442.338(a)(2) Meal Service 442.331(c) Dietetic Services 405.1125(c)

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	o Residents are fed slowly with head elevated o Supplies for mouth care are in evidence, observe if possible for technique, mouth shows evidence of good care (i.e., moist, clean).				

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F125	Nursing Services SNF (405.1124) ICF (442.338)					
F125	B. Twenty-four hour nursing. 1. Assigned duties consistent with their education and experience/ based on the characteristics of the resident load.	Are personnel performing duties that are allowed under the State Nurse Practice Act? Do you observe care being rendered in an appropriate, competent manner? Does the time schedule posted indicate that at least the minimum required personnel are scheduled and actually on duty?	Ask Resident o Do residents generally feel that people taking care of them know what they are doing? o If no, explain. o Are your treatments done in a consistent manner? o If no, explain. o Do you feel that there are enough people here to take care of you?	o Review progress notes to determine who is giving care. o Review care plan to determine who the facility has assigned the care responsibility to. o Check staffing sheets for minimal requirements and time and attendance for actual staffing.	All nursing personnel must function within their State Nursing Practice Act. Levels of staffing meet at least minimum requirements. Nursing care needs must be identified by the facility + documentation, resident and staff interviews should determine if these needs are met.	Patient Rights 405.1121(k)(g) Patient Care Policies 405.1121(1) Medical Records 405.1132(c) Content 442.318(a)(c) Patient Care Management 405.1124(d) 442.341
F126	2. Weekly time schedules are maintained.		o If no, explain. o How long do you usually wait for help when you put your call light on?	o Review charts maintained for ADL medications, I & O, restraints, etc. to assure that sufficient staff are available for carrying out responsigilities as specified in patient care plans.	All nursing staff should have education or training to prepare them for the care they perform.	
F127	3. There is a sufficient number of nursing staff available to meet the total needs of all residents.	Are call bells on for excessive periods of time without being answered? In SNF's is an RN on duty during the day? Are licensed staff and aide staff functioning in appropriate roles?	o Is there anything that doesn't get done as often as it should because there isn't enough staff to do it? Ask Staff o Do you feel qualified to do all the work you are assigned to do?			Staff Development 405.1121(h) 442.314
F128	4. There is a registered nurse on the day tour of duty 7 days a week (for SNF only)	Where are staff spending their time? Check for staff who are actually on duty.	o If no, explain. o Do your feel you have enough training to keep up with the care the residents require? o If no, what else do you need?			

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INTENT That all residents are cared for by personnel qualified to provide the care + that sufficient numbers + classifications of personnel are available.		o What other personnel do you need here in terms of numbers + classifications - i.e. aides, LPN's, R.N.'s, etc. o Do you think there is enough help in the facility? o If no, why?			

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Restorative Nursing Activities of Daily Living F155-159 SNF 405.1124(e) ICF 442.342 442.343(a)(c) INTENT To assist the resident to attain or maintain his/her maximum level of independence and function?	A. Observe residents in need of assistance. 1. Is needed assistance provided? 2. Is resident provided assistance and instruction, as appropriate, in all ADL's to increase his/her level of independence? 3. Does staff minimize pain/discomfort while assisting resident? 4. Is resident taught transfer techniques? 5. Is resident assisted to toilet in timely manner? 6. Resident personal equipment available & within reach? Glasses Hearing aids Dentures	Ask Resident: o What assistance do you need with bathing and/or dressing? Who helps you? o Does the staff plan with you your dressing/bathing schedule? o Are you able to dress/bathe at times convenient for you? o Are you bathed consistently? (i.e. on the day(s) scheduled does the bath get performed?) o Where are you bathed? (bed, shower, tub?) o Are there adequate clothes available for you to wear? o Do they come back from laundry in appropriate condition? o How do you get in and out of bed? o If staff assists you, do they seem to be able to do their job appropriately? Do you always feel safe when being helped? o Are staff members encouraging you to do things for yourself? o Do you have any problems getting to the bathroom on time?	Review: o Plan of care o Nursing notes Look for evidence of functional assessment and periodic review. Plan of care-Reflects assessment, goal, method to reach goal + who will provide the service. Note: Nursing notes show evidence of assessment, intervention if appropriate, progress toward independence or maintenance (Slowing of decline in function). Also, response to treatments/teaching. Plan of care reflects assessment, goals, methods to reach goals, and reevaluation.	Are patient needs identified? Verify that the plan of care addresses resident needs and is implemented as scheduled and that all appropriate information is documented. If goals are not reached, has a reevaluation been performed and goals revised? * Does restorative nursing assist the resident to acquire a higher level of independence? Is sufficient time allowed to resident for learning to increase his/her level of independence? Are assistive devices used regularly as per plan and are they in good repair? Is there an assessment, and if appropriate, a plan for each ADL that the resident needs to gain independece in? Maintenance goals should be noted as appropriate.	Physicians Services 405.1124(a)(b) Nursing Services 405.1124(a)(b)(c) 442.342 Dietetic Services 405.1125(a) 442.331(c) Activities 405.1131(a)(b) 442.345(a)(b) Specialized Rehab Services 405.1126 442.343(e)(1)(2)

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ADL's (con't)	Prosthetic devices (eg. braces, artificial extremities). Adaptive equipment (e.g., built-up spoon, reachers). Orthotic devices (eg. splints, AFO's). Restraints (eg. vest, waist, wrist, ankle, mitts, nets, geri-chairs). Grooming items (eg. comb, brush, shaver). Oral hygiene (eg. toothbrush, toothpaste, mouthwash, denture cup). Self feeding devices. Assistive devices for special sensory loss needs (eg. communication boards, large print books, magnifiers, writing tablets, picture cards, talking books). Training/re-training Prosthetic management Stroke adapted ADL's Self-injections of medications Bowel/Bladder Self-feeding Self grooming	o Do you have any problems with leakage when you sneeze, laugh or at any other particular time? o How does the staff help you with these problems? o Are they aware of the problems? o Do your bowels move regularly? o If not, what do you/staff do about this? o Are you able to feed yourself? o Are you able to get to the dining room by yourself? If not, why? In that case, what does staff do about this? o How long have you been up today? o Do you usually lie down for a rest? o If you need help getting into or out of bed, is staff available to help you when you need it? o Where do you spend most of your time - in your chair, wheelchair, or in bed?			

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	Ambulation Colostomy/Ileostomy Care Respiratory Care (oxygen inhalation) Speech Mobility Upper extremity dressing lower extremity dressing Observe at mealtime whether staff encourages/guides residents in self feeding or feeds the residents	o Does anyone move your arms or legs or help you with exercises? Who does this? o Have your sleeping habits changed since you came to the nursing home? If yes, why? o Are you able to get help during the night if needed? - What kind of help is needed? - Is staff response timely? o Do you feel there are adequate care supplies at this facility? o If not, can you give me an example of why you feel this way? o Is your family involved in assisting you or if learning to help you? o Do you feel there is is adequate staff at this facility? o If not, can you give me an example of why you feel this way?			

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SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
		o Does staff assist and/or encourage in activities (eg. R.O.M., ambulation ADL, communication programs, feeding) o How often does staff assist in activities o Is there anything resident would like to do for himself/herself that staff is doing? o Is resident comfortable (eg. free from pain) o Is your cane/walker/crutches comfortable for you to use? o Did anyone measure you so you have the right size cane/walker/crutches? o Did anyone show you the correct way to use your cane/crutches/walker? o Is the facility arranged so that you can get around fairly easily? Chair-bound Resident Ask Resident: o Does he/she know why he/she is in chair? o Is resident assisted to use bathroom? o Is resident comfort-			

LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
		able? o Does he/she see therapist (O.T., Speech, P.T.) and how often? o Does resident go to a therapy area or does therapist come to resident? o Is able to reach items needed? Wheelchair Resident Ask Resident o Does he/she know why he/she needs a wheelchair? o Is resident trained and/or encouraged in independent W/C ambulation and activity? o Does resident know how to lock and unlock wheelchair? Ask Staff: o How is resident set up for independent W/C ambulation? o Nurse Aide - has she received instruction in transfer techniques? For Bed Bound Resident In addition to appropriate interview questions above: Ask Resident: o How do you spend your day?			

LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
		o Can you do some things for yourself? o Does the staff give you a chance to learn some self-care skills? Ask Nurses Aide o Does this resident do any self care? o If no, has anyone tried to teach him/her to do some care?			

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SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
Positioning F158-SNF 405.1124 (e) Intent To assure that the resident is positioned at all times to promote maximum therapeutic benefit and comfort, as well as safety.	Observe residents in bed, chairs, restrained, or in "protective devices" for o body alignment o positioning o contractures (when did they occur + what is being done?) o ROM program (observe extent + technique of provider). o Assistance devices (overhead pulleys, slings, splints, etc.) o Turning/repositioning schedule and adherence to the schedule. o Devices to maintain positioning, i.e., sandbags, extra pillows, etc. Specific Observations for the Bed Resident. (as appropriate to condition). Positioning/body alignment Resting splints & correct application Foot positioning boards Trapeze Hand rolls Elbow/leg splints & correct application Restraints Siderails (padded)	Ask Resident o How often are you turned/repositioned by the staff? o Is that often enough? o Are you comfortable now? Do you have any pain or discomfort? Where? o How long have you had joint stiffness (contractures)? o Does someone help you move or exercise your arms and legs? o how often? o Do you wear special devices? How often? o Consistently? o Are they always applied and removed appropriately and promptly? How often? o By whom? Bed Rest Residentnow why Ask Resident - Why do you have to stay in bed? - How often does staff get you OOB? - Do they know how to get you up? - Who sets you up and/or assists you in bedside ADL's? - Does staff, therapist check positioning, supportive devices?	o MD orders for non-nsq interventioms/treatments. o Plan of care should include at a minimum: - Restorative goals - specific joints to be exercised - devices to be used in positioning - frequency of treatment or repositioning - resident teaching information - resident teaching information - services responsible for carrying out the procedures - dates for reaching goals o Nursing progress notes indicate: - Plan has been implemented - Progress toward goals - Response to information from reevaluation o Look for actual turning/repositioning schedule	Plan of care should be complete (addressing resident needs) and plan is implemented on a daily basis. Care givers are knowledgeable re plan content Residents are turned as scheduled. In good body alignment with proper assistive devices + equipment. Contractures are prevented and/or treated. Plan is reviewed, reevaluated and revised at least quarterly, but must be done as often as patient condition dictates Ask aide assigned to demonstrate the hand holds he/she uses for ROM. If aide doesn't know, ROM is probably not being done. Do it "at bath time" is not sufficient.	Rehabilitative Services 405.1126(h) 442.343(c)(2) MD Orders Activities Resident Rights Nursing-Staffing Inservice Social Service Dietary

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SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
	Special mattresses Blankets/pillows Clean, smooth linen Clean, appropriate bed wear Turning schedules ROM schedule O.O.B. (as tolerated) Water available All adaptive devices clean and in good repair All assistive supprotive devices clean and in good repair. Specific Observation for the OOB Resident in Chair (geri-chair, lounge chair in room, as appropriate to condition) Arrangement of room facilitates residents optimal independence (eg. independent eating, grooming, T.V., radio, water). Positioning/body alignment. Blankets/lap robe, pillows, foot stool. Hand rolls, splints Clean dry attire Pressure relief device Restraints, with release & activity schedule. Call bell available Fit and appropriateness of chair	- When? - Does staff answer call bells promptly? How soon? - Is resident able to reach items (e.g., water, call bell, urinal, emesis basin, tissues)? - How much confidence do you have when the nurses are helping you transfer, or turn and so on? - Does resident go to therapy area or does therapist come to resident? Bed Rest Resident Ask Staff - How often is position changed? - What activity is done at the time (e.g., R.O.M., toileting, OOB, grooming). - What can resident do independently? - Is equipment available? - Who maintains and cleans equipment? - What is schedule for this? - What training have you had to learn to position patients correctly?			

LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
	Specific Observation for the Wheel Chair Resident (as appropriate to condition) - Proper fit - Good working condition - Appropriate arm rest, footrest, leg support, lap tray - Proper positioning - Anti-decubiti device - Set up for independent W/C ambulation - Functional adapted toilet area - Transfer techniques Observe how staff wheel the resident (e.g., do they inform first?) Observe staff for: - verbal cues - physical support body mechanics Specific Observation for the Ambulatory Resident (as appropriate to condition) - Gait (steady/unsteady) - Appropriate devices for ambulation (e.g., cane, crutches, hemi-sling). - Posture - Appropriate staff assistance in ambulation	- Was there any part of your orientation when you first came to work here that addressed positioning? - Do you have any periodic reviews/ updates on positioning? Chair Bound Resident Ask Staff - How often is resident repositioned/taken out of chair? - What is activity at time of repositioning and or release of re-straing? - What can resident do independently? Ambulatory Resident Ask Resident Is resident encouraged to independently ambulate to and from activities and dining room. (With, without human assistance)? - Does resident do as much as he/she can independently? - What does he/she do? - How do you know that he/she is maximally independent? - If is not working independently, how do you deal with it?			

LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
	- Grab bars (halls, bath/shower area) - Functional adapted toilet area	- Is there something resident would like to do that he/she is not allowed to do (e.g., shave self, apply make-up, style own hair)? o What training have you had in learning to position residents and do range of motion? o What opportunity do you have for ongoing training? o Who does the actual training? Check question placement under Interviewing. May be more appropriate for resident's rights section. Observe wheeling technique used by staff.			

LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
Nursing Services F. __Administration of Drugs__ F166 SNF (405.1124(g)) 167 ICF (442.337) F168 1. The resident is identified prior to administration of a drug.	Observe a drug pass with at least 20 residents receiving medication. See SOM Appendix N. Transmittal No. 174 for details of the Surveyor Methodology for Detecting Medication Errors.	__Ask Resident__ o Do you always receive your medication on time? o If not, what is the problem? o Do you feel that residents here always receive the correct medication?	Review the medication administration record. (as appropriate) See S.O.M. Appendix N, Transmittal No. 174 for details of the record review.	If the combined total of significant + non-significant errors is 5% or above, a deficiency is present. Any significant error is cause for a deficiency. See Appendix N for details.	Physician Services 405.1124(b)(7) Pharmaceutical Services Supervision 405.1127(a) 442.336(a)(b)
F169 2. Drugs and biologicals are administered as soon as possible after doses are prepared.	- Observe medication administration techniques (e.g., handwashing, position of resident)	o Who gives you your medications? o Do your medications change in appearance? o Do the nurses stay with you when you take your medication? o Do any of the medications bother you?			
F170 b. Administered by same person who prepared the doses for administration except under single unit dose packet distribution system.		__Ask Staff__ o Do you generally have available the medications you need? o Are there any problems in administering medications?			
Exception: ICF residents may self administer the medications with their physician's permission.		Note drug doses refused by resident and how handled by staff.			

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LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
G. Conformance with Physician Drug Orders F172 173 SNF (405.1124(h)) F174 ICF (442.334(a)) Drugs are administered in accordance with written orders of the attending physician. Intent All residents receive medications as ordered by the physician.	Combine with observation of drug pass.		- Review the latest recap of the physicians orders - Review the medication administration record (as appropriate) - See S.O.M. Appendix N, Transmittal No. 174 for details of the record review	See Appendix N for details	Physician Services 405.1123(b)(7)

LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
DIETETIC SERVICES (Condition of Participation) F175 SNF (405.1125) A. Menus and Nutritional Adequacy F176 SNF (405.1125(b)) F177 ICF (442.332(a)(1)) F178 Menus are planned and followed to meet the nutritional needs of each resident in accordance with physicians' orders and, to the extent medically possible, based on the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences.	o Specific Observations which might be indicative of possible nutrition problems: Clinical - underweight/ overweight - dehydration - edema - cracked lips - pallor - dull or dry hair - swollen or red tongue - bleeding gums - decubitus ulcers - infections o Physicologic factors which may affect intake: - Vomiting - Food intolerance - Poor dentition - Sore mouth - Constipation - Diarrhea - Inability to feed self - Decreased visual and olfactory acuity - Unable to communicate - Loss of appetite o Psychological/Social - Confusion	Ask dietary manager to explain the procedure for making substitutions and recording the changes. - Is menu usually followed? Ask Resident: 1. How are your meals? 2. Are there foods you are not allowed to have? 3. Are you on a special diet? 4. Do you receive foods that are not appropriate for your diet? If so, what do you and the staff do about that? 5. What time do you receive breakfast, lunch and supper? Do you always receive a meal at mealtime? If not, why? What happens then? 6. Do you like the taste of the food? 7. Is the temperature appropriate (i.e., milk chilled, coffee hot, etc.)? 8. Do you get enough to eat? What do you do if you're still hungry after a meal?	Review Nutrition assessment for the following documentation: o Ideal body weight o Dietary allergies/ sensitivities, ability to chew and swallow regular foods without difficulty. o Full or partial dentures o Mental and emotional condition. o Physical appearance, skin condition. o Appetite and food preference. o Vitamin and mineral supploments. o Food and fluid intake in measurable terms and frequency of meals. o Degree of assistance needed in eating, related mobility, vision, or other identified problems. o Medications (e.g., diuretics, insulin, antibiotics, etc.) o Related laboratory findings (e.g., fasting blood sugar, cholesterol, sodium, potassium, hemoglobin, BUN, serum albumin, transferring if avialable).	o Were physician diet orders followed? o Did nursing plan for feeding and assistance at mealtime? o Is there rehabilitative use of assistive devices, if appropriate? o Is modification of consistency of meals made if resident has a problem or change in condition? o Are between meal and bedtime snacks provided as needed? o Is socialization at meals provided? o Has Dietitian provided counseling of resident and family as needed (related to diet) o Ideal/usual body weight? o Is there evidence that the plan is being carried out (e.g., documentation in the resident's chart, observation by the surveyor, and resident/staff interviews)? If the resident refuses meals or does not respond to intervention, the notes in the chart should indicate efforts to intervene or provide counseling.	Physician Services -405.1123 -442.346 Medical Records -405.1132 -442.318 Nursing Services -405.1124(e)(f) Specialized Rehabilitative Services -405.1126 PT. Care Management -405.1124(d)

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SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
	- Excessive food likes and dislikes - Refusal to eat o Selected biochemical changes which might indication changes in nutritional stutus: - Visceral protein status o serum albumin o transferring (if available) o Bun o Serum electrolytes During mealtime observe the resident for: - adherence to food preferences - adequate space for eating - self-feeding skills - Proper position for eating - Ability to eat foods served - Use of adaptive feeding devices - Amount of food actually eaten - Protection of resident's clothes - Amount of time resident is allowed to chew and swallow - Assistance provided as needed to and from dining area	9. Do you receive snacks in the evening? Do you have a choice about what you want to eat? 10. Do you receive medicines during meals? if yes, do you know what it is or what it is for? 11. Is there a resident council? 12. Do you get food from outside of facility that you buy or family brings? How often? What kind of food?	o Mental/emotional assessment as it relates to patient's food habits. Review: o Plan of Care o Nursing Notes Review: o Physicians orders o Progress notes o Notes from other professional disciplines as appropriate. NUTRITIONAL STATUS DEPENDS NOT ONLY ON ADEQUACY OF MENU PLANNING BUT ALSO WHETHER THE RESIDENT EATS THE FOOD AND HOW THE BODY USES IT. WHILE THE SURVEYOR IS NOT RESPONSIBLE FOR INDIVIDUAL NUTRITIONAL ASSESSMENTS OF RESIDENTS, WHEN SPECIFIC INFORMATION IS NEEDED DURING THE SURVEY TO MAKE A COMPLIANCE DECISION, THE SURVEYOR WILL UTILIZE THE FOLLOWING MINIMUM ASSESSMENT GUIDELINE: Menu Evaluation o Adequate in energy and nutrients - Protein - Calories	Is there evidence that the resident's progress is regularly observed (e.g., awareness of food and fluid intake such as acceptance of foods, food consumed, and resident's appetite)? o Is intake for resident on force fluids, Foley catheter, problem feeders monitored? o Is there general evidence as to whether poor resident conditions are due to poor care or whether the facility has taken appropriate measures to prevent or resolve problems. o Is there indication of progress toward desired outcomes? If not, is the evidence of re-evaluation available within specified time frames? o When the antropometric and ???????? data do not correlate with dietary data, (food intake, dietary supplements) the surveyor should take note that the problem may not be nutritional.	Nursing Services -405.1124(f)

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SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
	Assistance being provided in case of choking, incontinence, falling, or other emergencies.		- Vitamin C Selected evaluation of residents for in depth review: A check list can be used to evaluate daily menus for basic foods: Daily food plan MILK GROUP 1 pt milk MEAT GROUP 5 equivalents:* 1 equivalent equals 1 oz. of meat (edible portion) weighed after cooking (this includes eggs, dried peas, beans, nuts, and all meat, fish and poultry). VEGETABLE AND FRUIT GROUP 5 services or more, including a dark dreen or deep yellow vegetable for vitamin A value and a citrus fruit or other fruit rich in vitamin C daily		

LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
			BREAD-CEREAL-POTATO-LEGUME-PASTA GROUP		
			7 servings		
			FATS AND SWEETS		
			(Without this group the diet contains 1.415 kcal)		
			Adapted from handbook of Clinical Dietetics, The American Dietetic Association.		
			Observe serving portions.		
			Check milk consumption		
			Check amount of meat and eggs used.		
			Menus are dated and contained minimum portion size.		
			Are substitutions noted on the file copy?		
			Are substitutions made within the same food group, i.e., meat for another source of protein in the meat group, or vegetable of similar nutritional value?		

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SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
			o Documentation of decision to withdraw or begin artificial feeding and hydration. Check menus for variety Are they specific (i.e., states kinds of fruit, juice, vegetable)? DIETARY SERVICES SELECTED NUTRITIONAL REQUIREMENT RECORD REVIEW 1. Anthropometry - Weight /Height NOTE: These recommended formulas and guidelines are not the only acceptable guides available. The surveyor should ask to use the assessment guidelines used by the facility before using the ones provided here. o Important indicator of nutritional outcomes. o Disease state can have adverse effect on desired body weight.		

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SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
			2. Weight for Height Calculation Females: Allow 100 lbs. for first 5 ft. of height* plus 5 lbs. for each additional inch Males: Allow 106 lbs. for first 5 ft. of height plus 6 lbs. for each additional inch Estimating Caloric Needs 1. FORMULA: Harris-Benedict Equation Men: 66 + (13.7 x Wt) (Kg) + (5 x Ht.) (Cm) - (6.8 x Age)=BEE Women: 655 + (9.6 x Wt.) (Kg) + (1.7 x Ht.) (Cm) - (4.7 x Age)=BEE Parenteral Anabolic: 1.75 x BEE Oral Anabolic: 1.5 x BEE (Kcals)		

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SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
			Oral Maintenance: 1.20 x BEE (Kcals) Metric Conversions (Approx) pounds (lb.) x 0.45 = kilograms (Kg) inches (in.) x 2.5 = centimeters (cm) Estimating Protein Needs 1. Allow 0.8 gram protein per kilogram of ideal body weight. 2. Increase to 1.2 - 1.5 gm/kg for patients with depleted protein stores (decubiti, draining wounds, fractures, etc.). Fluid Requirement Based on actual body weight: Over 55 years with no major cardial or renal diseases: (NOTE: 2.2 lbs. equals 1 kg of body weight)		

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SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
			Example: 120 lbs/2.2 lbs. = 54.5 kg (55 kgs) 55 kg x 30 cc - 1,650 cc/day Note: Standard Tube Feeding = approximately 80% water.		

Amputation	% of Body Weight
Leg	20%
Below Knees	10%
Arm	6%

Suggested Standards for Evaluating Significance of Weight Loss

% of body weight loss

Interval	Significant Loss	Severe Loss
1 week	1-2%	>2%
1 month	5%	>5%
3 months	7-1/2%	>7-1/2%
6 months	10%	>10%

From Blackburn, et al. "Nutritional and Metabolic Assessment of the Hospitalized Patient" JPEN vol. 1, 1977.

Lab Indices for Visceral Proteins

	Mild Deficiency	Moderate Deficiency	Severe
Albumin g/dl	<3.5-3.2	<3.2-2.8	<2.8
Total Lymphocyte Count (cu/mm)	<1800-1500	<1500-900	<900
Transferrin	<200-180	<180-160	<160

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SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
B. Therapeutic Diets F179 SNF (405.1125(c))	System for the provision of diets: o Dietetic service Kardex or file o Therapeutic menus	Ask Staff: o Number, type of therapeutic diets? o Time of nourishment activity, who's responsible?	Review: - Physician diet orders in medical record - Nurses' Kardex - Dietary Kardex		Nursing Services 405.1124 (d.) Pt. care plan (f.) Supervision of patient nutrition
F180 ICF (442.332(b)(1)(2))	o Nourishment preparation and service o Adequacy of nourishment o Individual menus or diet cards	o Nourishment provided for day of survey	- Therapeutic diet menu - Diet cards		
F181 1. Therapeutic diets are prescribed by the attending physician.	SPECIAL FEEDINGS: The surveyor should also attempt to observe that: o Staff use proper technique in administering feedings and medications. Check to see that staff checks for location of tube before feeding and that tubing is irrigated before and after addition of medication.	The surveyor should interview staff regarding their knowledge of the feeding schedule and training in administering tube feedings. Some residents having difficulty in speaking or swallowing with the tube in place (i.e., poor toleration).	Note: - Consider appropriateness of special diet-updated & review since admission - Progress notes reflect reevaluation of resident's progress on diet.		
F182 2. Therapeutic menus are planned in writing, prepared, and served as ordered with supervision from the dietician and advice from the physician whenever necessary		The surveyor should inquire if mouth feeding was attempted. Ask Resident: If the resident is able to be interviewed, suggested questions may be: 1. How long have you been fed by this tube? 2. When was the last time you tried to eat by mouth? What happened? 3. How often do you receive the feeding? Is this consistent?	Selected number of residents on therapeutic diets should be considered for indepth reviews. Pureed: Tube Feeding Review: - Plan of Care - Identify frequency, amt of feeding based on the physician's order and the time span over which each feeding is accomplished. - Medication and treatment recordstation present - Fluid intake records - Number of calories as	On Pureed diets: o Ordered by physician o after 48 hours prepared fresh daily o Same calories and/or food groups as if served whole. On Tube Feeding: o Has the feeding been ordered by Physician? o Is tube feeding nutritionally adequate? o Have attempts been made to discontinue tube feeding if indicated? o Have changes in resi- dent condition been noted and [illegible]	

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
continued	FOR THE RESIDENT WITH DECUBITUS ULCERS				
F181 Therapeutic diets are prescribed by the attending physician	Functioning system to provide the needed nutrients: -Resident's general appearance	Ask Staff Regarding knowledge of dietary needs o What do you do when this resident refuses mied, meats, bread, etc.?	1. Identify residents with conditions that immopolize or prevent voluntary body movement. 2. Identify location, number, size and depth of decubitus ulcers.	A system is in place to provide the type and amount of nutritional support needed by the residents who have developed decubitus ulcers.	Nursing Service 405.1124 (d) (b)
F182 Thereputic menus are planned in writing, prepared and served as ordered with supervision from the dietitian and advice from the physician whenever necessary.	-Meal service -Food acceptance -Adherence to food preparation -Food Supplement -type to support nutritional assessment -method of service -assistance provided -timely provision as ordered -Portion sizes	o What nurishments are provided this resident? How often? o What happens when a weight loss is noticed with this resident? Ask Resident o Has anyone talked with you about the importance of eating your meals? o Do you get foods that you don't eat on your tray? o Do you feel hungry? o Do you get between meal snacks?	3. Calcualtions of relocaloric and protein levels needed. 4. Micronutirient need assessment and recommendation. 5. Progress notes -monitor out -monitor heading of decubilus ulcers. 6. Pertinent Laboratories Data -Hemopohin/Demotocrat -Screen Albumin -Total Lumphocytic Count 7. Intake -Sufficient to maintain hydration	Food and supplementation are provided in a method to ensure intake of nutrients needed by residents with decubitus ulcers	

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SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
			well as amount of additional water - Periodic reassessment of ability to swallow - Record should indicate measures taken to prevent diarrhea and constipation and to treat if they have developed.	weight loss, constipation, diarrhea, skin condition)? o Have observed problems been coordinated with other departments and resolved? o Is feeding being monitored to ensure that feeding is occurring at the ordered/appropriate rate? o Varied supplements as preferences allow?	
		Interview staff regarding knowledge of diabetic diets. o What nourishment does the diabetic patient receive? o If diabetic patient refuses the meal, what is done to supplement the meal? If resident is able to be interviewed, suggested questions: 1. How long have you been on your diabetic diet? 2. Do your know some of foods you must avoid? What are they?	Diabetic Diets Review: o Pertinent Laboratory data: - urinary glucose - serum glucose o Wt. gain/losses	On Diabetic Diets o Ordered by Physician o Varied, nutritionally adequate o Individualized to suit resident o Re-evaluation indicates diet meets objectives. If not appropriate, documentation is provided o Laboratory results support diagnosis o Between meals snacks provided as needed	

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SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
	Observe tray/meal service: o Palatability of Low-Sodium diets (TASTE) o Sugar sources on diabetic diet trays o Salt sources on sodium restricted diet trays	3. Do you receive a nourishment between meals or before going go bed?			

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SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
F181 Therapeutic diets prescribed by the attending physician F182 Therapeutic menus are planned in writing, prepared and served as ordered with supervision from the dietician and advice from the physician whenever necessary.	RENAL System in place for the correct provision of renal diets. *Individualized menu *Dietary Staff Utilize menu when serving diets	Interview Staff regarding knowledge of renal diets: *What foods should be restricted when a patient has kidney problems? *What nourishments are given to these patients? *Are fluids restricted? Ask Resident: *Are you on a special diet? *What foods must you avoid? *Do you feel hungry? *Do you eat everything at mealtimes? *Are the foods the kitchen sends you the correct ones for your diet? *Has the dietitian explained your diet to you?	Renal Patient Diet Review *Pertinent Laboratory Data BUN Serum Potassium Albumin Hematocrit Creatinine *Pertinent Medications Vitamin/Mineral supplements *Weight gains/losses	On Renal Diets *Ordered by physician *Written menu nutritionally complete in so far as medically possible, including calories *Individualized to suit resident *Laboratory testing as needed *Coordination with dialysis unit to determine effectiveness of diet	Nursing Service 405.1124 (d)PT Care Plan (f)Supervision of Patient Nutrition

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SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
C. Preparation F187 SNF (405.1125(e))	Observe: o Assistance provided or not provided by staff		Review: o Plan of Care o Progress notes o Notes from other professional disciplines to determine rehabilitation potential to self feed, use of assistance devices o Record of food substitution to determine alternate choice provided o Standardized recipes	The facility has kitchen and dietetic service areas adequate to meet the food service needs. These areas are properly ventilated, arranged, and equipped for sanitary refrigeration, storage, and preparation of food. Equipment and storage areas are clean, well maintained, within proper temperatures ranges, and safe Proper temperatures: (Fahrenheit) Frozen food storage -- 0 or below Cold food storage -- 40-45 degrees Hot food holding equipment -- 140 degress minimum Dishwasher wash cycle -- 140 degrees Dishwasher rinse cycle -- 160-180 degrees or a color change in thermo-paper Adherence to manufacturers recommendations	
F188 1. Food is prepared by methods that conserve its nutritive value and flavor.	o Length of time residents sit and wait for meal service o Food is served soon after cooking or refrigerated o Trays are free of spillage of foods or liquids				
F189 2. Meals are palatable, served at proper temperatures. They are cut, ground, chopped, pureed or in a form which meets individual resident needs.	o Foods are appropriately covered and kept at a proper temperature o Cooking and service utensils are clean, sanitary and greaseless o Refrigerated foods must be covered o Leftover and pre-cooked foods must be dated and labeled o All cooked food stored above raw meats in refrigerator				
F190 3. If a resident refuses food served, appropriate substitutes of similar nutritive value are offered.	o Temperature gauge on or in refrigerator to record temperature o Shelving to allow air circulation o Food not stored in refrigerator must be stored off the floor o No rust on shelves o No dripping or spillage on shelves and floors o Degree to which diet modification is commen-				

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SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
INTENT To provide foods that are safe and nutritious	surate with resident's tolerance and capability o Residents for meal satisfaction o Observe appearance of food color, texture, aroma, and flavor			Dietary personnel are clean and free of infectious disease. They practice acceptable techniques and procedures to keep foods at proper temperatures and protected against contamination. Is dietary information pertinent to dietary modification? Has resident been value as the refused assessed for eating program to maintain independence?	
F190 (Cont.)	F190 o Less than 75% of meal is consumed o Type of substitutions provided		o Progress notes o Diet card o Days substitute record	Is the food substitute of similar nutrition value as the refused item (e.g., milk refused, alternate of calcium or calcium supplement should be provided.	

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SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
D. Frequency F191 SNF (405.1125(d))	o Menus as under (A). o Check time of meal service o Who serves nourishments o Nourishment list and schedule	Interview various residents about the nourishment service: o Are nourishments offered routinely? o At what time are they offered? o By whom? o What kind of nourishments are offered?	**Review** o Menu as under A o Nourishment List	Three meals or their equivalent are served daily with not more than a 14-hour span between the evening meal and breakfast. The nourishment service is more difficult to evaluate: must find evidence that patients are offered nourishments even though it is on an unplanned basis.	
F192 ICF (442.331(a))					
F193 1. At least three meals are served daily at regular hours with not more than a 14-hour span between a substantial evening meal and breakfast.					
F194 2. To the extent medically possible, bedtime nourishments are offered to all residents Exception: Not required for ICF Residents.					

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E. Staffing F195 SNF (405.1125 (a))	Food service personnel are on duty for all defined dietary responsibilities: - Supervision - Food Preparation - Dishwashing - Cleaning	o Interview personnel to verify that they are aware of their responsibilities and job descriptions.		o From an assessment of the total dietetic service operation, there is evidence that the dietetic supervisor is capable of the overall management and supervision of the dietetic service. o There are dietetic personnel on duty over a 12-hour period who demonstrate ability to perform tasks adequately. o Dietetic personnel receive appropriate orientation and training consistent with their duties and responsibilities. There is evidence that the dietetic staff are knowledgeable about food service policies and procedures and apply these accepted professional practices in their daily work.	
F196 1. Food service personnel are on duty daily over a period of 12 or more hours. Intent Persons are providing services commensurate with their level of training; and at the level of sophistication needed by the residents.	o Duty Schedules				

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SPECIALIZED REHABILITATIVE SERVICES F197 SNF(405.1126) F198 SNF(405.1126(b) Indicators A thru C apply to SNFs. F199 A. **PLAN OF CARE** ICF (442.343(e)(1)(2) F200 Rehabilitative services are provided under a written plan of care, initiated by the attending physician and developed in consultation with appropriate therapist(s) and the nursing service. B. **THERAPY** F201 ICF (442.343(a)(c)(d) Therapy is provided according to orders of the attending physician in accordance with accepted professional practices by qualified therapists or qualified	**OBSERVE RESIDENTS** As per "Restorative Nursing Activities of Daily Living" SNF - 405.1124(e)2(b) ALSO: **OBSERVE RESIDENTS IN THERAPY AREAS**: -Is privacy provided during treatment, as applicable? (e.g. cubicle curtains, room dividers, one to one area) -Is there appropriate, courteous resident/staff interaction? -Are therapy areas appropriate to treatment given? (e.g. small, quiet area for speech/hearing tests and sessions, large area for p.t., exercise and therapy groups, o.t. perceptual testing/splinting, A.D.L. adaptations are as applicable) -Is equipment clean and in good working condition? Is it operating as per manufacturer? (e.g. hydrocollator temp., parafin, whirlpool, etc.) -Are assistive devices being provided as needed? -Do assistive devices fit well function and are	**ASK RESIDENT** (or ask staff, if resident has severe communication problem): -Are you receiving any kind of therapy? P.T.? O.T.? speech? -Why do you need therapy? -How often to you see the therapist? -Do you receive therapy on weekends? -What happens if the therapist is absent for scheduled treatments? -Where do you receive your therapy? -How long have you been receiving therapy? -Do other staff members assist with therapy? Who and in what way? -Are you comfortable during therapy? (free from pain, privacy maintained, etc.) -Do you have input into developing or revising your therapy treatments? **ASK THERAPY STAFF**: -How many days/hours per week do you provide therapy? -Do you participate in the development of the resident overall plan of care? In what way? -Do you utilize PT "aides"? In what way? (if interviewing the registered physical therapist) -How do you assure carry-over of therapeutics in your absence? -How often do you provide inservice to staff? What topics are covered? -Do you have opportunities to attend inservices? -How do you communicate patient progress/regression, etc. with physician, nursing personnel, family, other disciplines)? -How many residents currently are receiving P.T., O.T., S.T.? -Do you utilize the services of a certified occupational therapy assistant? (if interviewing the registered occupational therapist) If so, in what way? -Is space available for the conduction of your therapy?	**REVIEW**: -Plan of care -Doctors' orders -Nursing assessment and progress notes -Aide assignment sheets -Therapy assessments/evaluations (includes a minimum of): *name, age, date, diagnoses *referring physician and reason for referral *history, precautions, limitations *objective documentation (e.g., tests, measurements) *rehabilitation potential -Treatment plan (includes a minimum of): *specific rehabilitation needs and objectives *treatment to meet specific measureable rehabilitative goals *type, amount, frequency, duration, modalities *name of therapist(s) who will provide treatment *restorative nursing follow-thru (recommendations for plan of care) *identifies modalities that will be delegated to non-skilled staff -Progress notes indicate that plan of rehabilitation care has been reevaluated by the physician and therapist as necessary but at least every 30 days. -Communication with physician: *2 week progress *monthly progress *discharge summary -Treatment documentation: *at frequency *summarized	-Are rehabilitation services integrated with restorative nursing? -Do therapists participate in development of resident plan of care? -Do observations and interview indicate that services are provided in conjunction with 24 hour nursing, and in accordance with the overall plan of care regarding restorative nursing and specialized rehabilitation services?	**NURSING SERVICES** 405.1124 442.338 442.339 442.341 **PHYSICIAN SERVICES** 405.1123 442.346 **MEDICAL RECORDS** 405.1132 442.318 **ACTIVITIES PROGRAM** 405.1131 442.345 **RESIDENT RIGHTS** 405.1121(k) 442.311 **TRAINING** 405.1121(h) 442.311 **INFECTION CONTROL** 405.1135 442.315 442.327 442.328 **PHYSICAL ENVIRONMENT** 405.1134 442.324 442.325 442.326 442.328 442.329 442.330 **DIETETIC SERVICES** 405.1125(e) 442.329 442.331

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assistants. C. PROGRESS F203 ICF(442.343(f)) F204 1. A report of the resident's progress is communicated to the attending physician within 2 weeks of the initiation of specialized rehabilitative services.	used properly (e.g. wheelchairs, crutches, braces, glasses, hearing aids, canes, artificial limbs, assistive eating devices)? -Is resident free of pain during treatment and is staff responsive to resident expressions of discomfort? -Is resident receiving appropriate training and/or re-education (e.g. stump management, selfranging, alternative communication methods, hearing aid care, etc.)	-Is equipment readily available to meet resident needs? -Is there a coordinated interdisciplinary approach toward rehabilitation of the geriatric resident evident in your facility? In what way do you see this?			
F205 EXCEPTION: ICF Resident's progress must be reviewed regularly.	-Are parallel bars sturdy and well secured to floor?				
F206 2. The resident's progress is thereafter reviewed regularly and the plan of rehabilitative care is reevaluated as necessary. But at least every 30 days by the physician and therapist.	-Are systems designed for weight lifting sturdy and well secure if attached to wall with rigging and hand grips in good condition? -Are nonverbal residents provided with means of communication (e.g., writing tablets and utensils, picture cards)?				
F207 EXCEPTION: ICF residents' plan must be revised as necessary.	-Are visually impaired residents provided with magnifiers and large print books?				

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INTENT Therapy services are provided that will assist the resident to attain his/her optimal level of function.	-Is equipment such as whirlpool cleaned between patients?				

LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
Pharmaceutical Services F208 SNF 405.1127 F210 A. Supervision F211 ICF442.336(a) (b) F212 SNF405.1127(a) The pharmacist reviews the drug regimen of each resident at least monthly & reports any irreqularities to the medical director and administrator. F213 A registered nurse may be utilized to perform this review for ICF residents. Also, the attending or staff physician must review medication quarterly.	o Observe residents for excess sedation or adverse affects: -drooling -shuffling gait -involuntary movements of limbs, tounge, facial muscles -loss of affect -drowsiness -postural abnormalities -pill rolling movements o Observe for depression aggitation	Ask Resident o Are you aware of the medications you are taking--use, frequency, contraindications? o Has your physician discussed the medications you are taking with you? o How many medications are you taking? o Do you feel the medications help you? o Do any of the medications bother you, for ex: make you feel nauseated or dizzy? If so, have you told anyone about it? Ask Staff o How often does the pharmacist review the residents' medications? o To whom does he report any irregularities? o When the pharmacist reports irregularities, what is done about it? o To whom do you report any problems about medication? o Do you feel the residents are receiving the proper medications, amount and kind? o Is the pharmacist available to you for consultation? o Where does the pharmacist perform his drug regimen review?	o Review medical record: -to see if pharmacist or nurse has reviewed a drug regimen on a monthly basis. -for evidence that the reviewer has reported irregularities to the physician or other who has authority to correct the irregularities for evidence that the irregularities have been evaluated -review nurses notes, progress notes, care plan, etc. for any adverse reaction to medication and indication that corrective action was taken. -screen the drug therapy of the targeted residents using the indicators (forms if prepared) outlined in SOM Appendix N Transmittal #174 -review pharmacists drug regimen monthly reports to determine if pharmacists has commented on potential irregularities. Screened out through this process (need full year).	o Reviews were performed in the facility. o There was evidence of a review performed on every resident whose record was reviewed indepth. o In records reviewed the average perscription utilization was not substantially over 6.1. If it is, review for appropriateness. o Apparent irregularities were identified and reported. * Refer to SOM appendix N in 174 for further information on drug regimen review.	Physicians Services 405.1123 (b) 442.346 Nursing Services 405.1124 442.338

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SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
B. Labeling of Drugs and Biologicals F214 SNF 405.1127(c) F215 ICF 442.333 F216 The labeling of drugs and biologicals is based on currently accepted professional principles and includes the appropriate accessary and cautionary instructions as well as an expiration date when applicable. INTENT To assure that residents receive medications as ordered and that they are monitored for possible side effects.	Observe labels of medications for residents observed on drug pass tour for: -name of drug -dosage form -strength of drug -quantity of drug -name of manufacturer -expiration date -central number -appropriate accessory or cautionary statements				

LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
Laboratory and Radiological Services F217 SNF 405.1128 F218 SNF 405.1128(a) A. Provisions of Services F219 1. All services are aprovided only on the orders of a physician. F220 2. The attending physician is notified promptly of diagnostic findings F221 3. Signed and dated reports of a clinical laboratory, X-ray and other diagnostic services are filed with the patient's medical record. INTENT To assure that lab tests are performed as ordered and findings are reported to physicians to assure that phys. are made aware of symptoms that may req. lab tests	Observe symptoms of targeted residents e.g., drainage, odors, jaundice, fevers, edema, etc.	Ask Staff o What do you do when you think a resident needs laboratory work done-blood work, cultures, etc.? o How long does it take to get lab results back? o What do you do with the results when they do come back? o Do you have any problems with your laboratory services? o How are lab specimens stored? o Do you have any instruction from the lab regarding collection and storage of specimens?	Review the physician's order sheet to see if: -orders for lab services are signed -that there are orders for tests that have been done. Nursing progress notes are reviewed for documentation of physician notification of lab results. Physician progress notes or other documentation indicating that the physician is aware of lab results. There are lab reports on the medical record for all tests ordered (except if just performed)	There must be signed physician orders for all lab/radiology services performed. Record results of all testing in the medical record. There is documentation in nursing or physician notes to indicate that results of lab tests were promptly communicated to the physician.	Nursing Services 405.1124 (a)(b)(c) 442.343 Physician Services 405.1123 (b)

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SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
SOCIAL SERVICES F222 SNF (405.1130) F223 SNF (405.1130 (a)) A. Plan F224 ICF (442 344(d)) F225 The medically related social and emotional needs of the residents are identified. B. Provision of Services F226 ICF (442 344(a) (b)) F227 1. Services are provided to meet the social and emotional needs by the facility or by referral to an appropriate social agency. F228 2. If financial assistance is indicated, arrangements are made promptly for referral to an appropriate agency.	Observe resident for: o level of alertness o behavior exhibited. (disoriented, confused, uncooperative, disruptive, aggressive, anxious withdrawn, isolated lonely) o personal appearance o apparent disabilities o apparent vision and/or hearing problems they exhibit as you talk to them o Interaction with staff, other residents, family, visitors o Participation in group activities o Independence in activities, decision-making o Therapeutic staff intervention: constructive reaction to resident's behavior o Resident participation on policy-making bodies and committees of facility, e.g., resident councils.	o How long have you been in the facility? o Can you explain to me why you are here? o Have you had any problem adjusting to the facility i.e., loss of independence? o Have you had any other problems? o Has staff been helpful, e.g. financial? o Do you have any family or any other visitors? o Do they have any problems with which this facility has not been helpful? o If exibiting disruptive depressed, agitated, anxious etc. behavior--I noticed that you are upset (quiet, nervous, unhappy) today. Can you tell me what has bethered you? o Does staff respond to your suggestions about your own care? o Did you participate in planning what care you will get and who will give it to you? o Do you made use of the dining, activity, community room, and/or outdoor area? o Can you tell me about your life here? What do you do in a usual day? o Are things like getting up, bathing, dressing, eating done at the same time for everyone? o If you could change some things about living here what would you change? Ask Social Worker/Nurse o Who is responsible for identifying the resident's: -Social and emotional needs. -Family and home situation. -Problems and needs. -Financial needs.	Review medical records of residents selected for indepth review to determine that: o Assessment and plan of care identifies resident's medically related social and emotional needs and/or problems. o Resident's family and home situation, information related to medical and nursing requirements, and community resources are considered in making decisions regarding the residents care. o Medical records contain current specific information signed and dated which highlights the social and emotional needs of the resident and significant findings and actions are entered promptly in the medical record. o service notes address the if applicable. -losses due to aging -Relationship with staff and other residents -Mental status -Behavior problems -Adjustment to the facility -Illness o Plan of care, social service notes, reflect the current status of the resident. o There is evidence that the residents mental status has been considered when plan of care was developed. o Vision and hearing problems have been addressed. o Plan of care addresses residents needs as observed by the surveyor and stated by the resident. o Notes and plan indicate that needs have been re-evaluated and care plan changed as necessary. o There is evidence that the problems and needs of the family have been addressed. o There are indications that a referral has been made to the appropriate agency and a statement describing why.	o The residents social and emotional needs are identified o The plan of care addresses those needs. o The plan of care is being followed, reviewed and revised as necessary. o The family's needs and concerns are addressed if applicable. o There is referral to appropriate agencies if necessary. o Sufficient space is provided for private meetings and discussions	Nursing Services SNF 405. 1124 ICF 442. 338 Activities SNF 405. 1131 ICF 442. 345(a) (c)(d) Physicians Services SNF 405 1123(b) ICF 442 346 Patient Care Managemt. SNF 405. 1124(d) ICF 442. 341 Physical Environment SNF 405. 1130(b) ICF 442 344(c)

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SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
		o How are needs identified and reported? o Does resident participate in the development of his/her care plan? o Ask nursing how often the social workers sees resident. o Does the social worker discuss residents needs/problems with nursing staff if there is a need for nursing to be involved. o How is physician notified and involved in plan of care. o Ask social service staff their role, function, and what services they provide. o Ask staff what referral services are. o If services are being provided by outside resource are resources documented work service. o Ask social service staff about their background and education. o If there is a consultant ask staff: -How often does the person come. -How long do they stay. -What does the person do while in the facility. -What assistance, consultation is being provided. o Ask social service staff if adequate space is provided for them by the facility to conduct private interviews and meetings.	o There is documentation from the outside agency indicating what actions were taken and any planned follow-up. o The time period between date of referral and date of services is reasonable and if not, there is evidence of follow-thru by staff. o The outside agency has documented their involvement and activities. o Plan of care demonstrates awareness of behavior, articulates the reasons for it, and indicates in the plan of care an approach to the behavior. o Assessment should contain: -A flexible approach to each resident (should be individualized). -Awareness of a mental status evaluation. -Resident history. -Family availability for planning, resident support, etc. -Identification of problems resulting from placement. -Recent social adjustment. -Discharge planning. o The record reflects Social Service iintervention with family and resident, i.e., grief and berievement counseling. o Review integrated plan of care for -Plan for concerte social services -Plan for supportive services for adjustment. -Adjustment goals. -Interventions for specific conditions.	o There is evidence of collaboration between nursing and social work for meeting emotional needs.	Patient Care Managemt. 405. 1124(d)

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SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
F229 Activities F230 SNF 405.1131(b) F231 ICF 442.345 (a) (c)(d) F232 1. An ongoing program of meaningful activities is provided based on identified needs and interests of each resident. It is designed to promote opportunities for engaging in normal pursuits, including religious activities of their choice, if any. F233 2. Unless contraindicated by the attending physician, all residents are encouraged to participate in activities. F234 3. The activities promote the physical, social and mental well-being of the residents. F235 4. Equipment is maintained in good working order. F236 5. Supplies and equipment for activities of interest are available.	General level of activities throughout the facility, as well as in specifically designated areas. How many residents are lying on their beds or sitting in chairs staring at the walls during the daytime hours? What is the level of residents interest in activities they are doing? Are residents positioned correctly for activity? Are needed personal equipment (e.g., splints, glasses) and adaptations for limitations and safety (e.g. card holder, goggles, footrests) used in activities?	How does he/she spend the day? Of the activities resident has during the week, what does he/she enjoy most/least? If has none, why? Has staff asked about his/her interests? Suggested specific activities or people to get acquainted with in response to interests? What organized activities has he/she participated in this past week? How does resident find out about upcoming programs or happenings? Does resident get out of facility to activities? Does resident have problems getting to activities? If so, does the staff assist? Does the staff encourage residents to go to activities? Does resident participate in Resident Council? Does resident have free choice of activities?	Activities Assessment Interests of the resident (past, present and future) are identified as to subjects level (strong levels) and any special conditions. Evidence that information about social history, medical problems and limitations impacting residents' activities have been communicated to activities personnel and used in assessment and development of activities portion of care plan. Needs of the resident in the following areas are identified: - social interaction - creative expression - work and service opportunities - intellectual stimulation or activities adaptation - physical exercise - spiritual or religious expression Plan of care Used all available information about - interests - needs - indications and contraindictions for activities from other assessments	Are each resident's interests known? If not, what actions are being taken to identify them? No more than 10% of residents in facility 60 days should be without some identified interests. Are each residents needs identified? If not, what actions are being taken to identify them? Have medical contraindications been identified in the care plans? Needs and contraindications of at least 85% of residents in the facility more than 30 days should be known and/or have a plan of action. Does each resident have multiple activities or interest daily? Does each resident's activities promote his physical, social and mental well-being?	Nursing Services 405.1124 442.319 Social Services 405.1130 442.344 Special Rehabilitative Services 405.1126 442.363 Physician Services 405.1123 442.329 Phys. Environment 405.1134 442.329 Infection Control 405.1135 442.328 Resident Rights 405.1121 (k) 442.311 Medical Records 405.1132 442.318

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Intent Each resident has individual and/or group activities to meet activities needs through his interests daily	Is lighting adequate for activities in which residents are engaged? Do men have activities of interest to them? Do residents communicate with each other in activities? Are methods of communicating upcoming activities appropriate to the resident populations? Specific observation for physically impaired/alert residents: Activities adapted to meet specific needs of the resident (e.g., weighted checkers, earphones, needle threaders). Alert residents have activities of interest and at their cognitive functional level. Specific observations for confused/disoriented, emotionally disturbed and mentally retarded residents. There are current calendars, clocks	Do they know the interests of residents under their case? TV programs they like? Activities they want to participate in today/this week? Do they know the personal equipment needed (e.g., glasses, hearing aids, reacher)? Do they know the adapted equipment used by residents for specific activities (e.g., talking books, built up tools)? Do they talk to residents to identify new interests and report these and "dislikes" to activities personnel? How? What is staff's involvement with individual and group activities of residents in their care? How do they determine interests of residents who have difficulty communicating? What activities does resident participate in regularly? Which activities does he/she enjoy most/least? If he/she does not participate, why? Which activities appear to relax/calm the resident? Excite him/her? How does staff manage maladaptive behavior (e.g. abusive, disruptive, combative)? Is direct care staff involved in resident activities? How? When (weekends, evenings)? Does resident have one-to-one assistance in activities?	Activities notes spell out implementation of plan, resident's reactions to specific activities, approaches, and people. Residents' participation in individual and group self-started and organized structured and unstructured activities timespent. Evaluation of plan of care for: changes in interests; changes in precautions, changes in needs, new problems, approaches, etc. Revision and updating of plan.	Are equipment and supplies to meet residents interests available and maintained in good working order? Are residents evaluated periodically with emphasis on participation levels and desire for new activities? Are plans readjusted if they do not reach desired outcomes? At least 70% of all residents in the facility more than 60 days should have at least two activities a day of interest to them personally to be considered in compliance.	

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SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
	and patients names or symbols in proximity to residents rooms. Staff consistently reinforce reality orientation. Resident has familiar items in room (e.g., family pictures, artwork, afghan, chair from home. Residents in restraints have activities of interest geared to their abilities when restrained (e.g., table-top activity, music, radio, reading and writing material; when out of restraints (e.g., walks, exercise, group, toileting) Small group and one-on-one involvement with staff reinforcing appropriate responses. Staff reaction to resident behavior (e.g., crying, whining, demanding non-verbal, aggression, loudness).	How many residents have fewer than 2 hours of activities a day of interest to them as individuals? Why do these residents have so little of interest? What is your plan to find more activities of interest to them that will meet their needs? What types of residents seem not to be interested in activities? How many (who) residents have only passive activities? How do you adapt activities for needs of residents who are: - confused/disoriented - emotionally disturbed - mentally retarded - physically impaired but alert - terminally ill. What types of activities are available for needs of the comatose? Are community volunteers utilized in the activities program? In what way? Are the residents encouraged to offer suggestions for new activities? If so, what activities have been instituted as a result? Are evening, weekend, holiday programs provided? How they manage maladaptive behavior, (e.g., abusive, disruptive, combative)? How do they help depressed residents (e.g., tearful, emotionally liable)?			

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SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
	Specific observation for comatose or terminally ill resident: Appropriate items for sensory enrichment in room (e.g., TV, radio, adequate lighting)				
	Resident placed in supportive living environment (e.g., around people, in hall, activities room, sunshine, fresh air).				
	Specific observation of environment for conducting activity program: Adequate lighting throughout the facility.				
	Functional area appropriate for activities of interest (e.g., religious services arts and crafts, cooking, reading, TV watching, card playing, parties, discussion groups, gardening.				
	Multi-purpose room use and timing of activities does not conflict.				
	Outdoor activity area				
	Functional furniture, indoors and outdoors.				

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SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
	Evidence of free choice activities: - newspapers - magazines - record player - radios - clocks - calendars - TV's				
	Activities, equipment and supplies are age appropriate and sufficient to meet interests of residents.				
	Activities, equipment and supplies sufficient for conducting activities.				
	Activities equipment clean and in working order.				
	Resident rooms contain independent project materials, as appropriate.				
	Residents utilize the total activity environment (e.g., lobby, sunroom, dayroom, porch, dining room.				

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SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
PATIENT CARE MANAGEMENT F237 SNF (405.1124(d)) F238 ICF (442.341) F239 A. Each resident's needs are addressed in a written plan of care which demonstrates that the plans of all services are integrated, consonant with the physician's plan of medical care, and is implemented shortly after admission. F240 (442.319) B. Each professional service identifies needs, goals, plans, and evaluates the effectiveness of interventions, plus institutes changes in the plan of care in a timely manner. INTENT The intent is to assure that the facility identifies the resi-	Observe resident level of physical, mental, emotional and social functioning. Note problems, potential problems, needs, using observation/interview/record review work sheet.	ASK RESIDENT: - Are you aware that you have a plan of care? - Did you participate in developing a plan of care? - Do you/your family know what plan is and details? (e.g., diet, ambulation, dressing, etc.) - Do you attend plan of care meetings? - Who else attends the plan of care meetings? - When did you last attend the meeting for your plan of care? - Does the staff assist you in achieving the goals on the plan of care? If not, who does or why not? - Do you have all necessary assistive devices and equipment? - Is there anything that is not part of your plan of care that you think should be included? ASK STAFF: - What is your input into resident's plan of care? - What aspects of resident plan of care are you carrying out? - What is this particular resident's plan of care? - How do you assist the resident in carrying out the plan of care? - Who attend the care planning meetings?	REVIEW: - Plan of Care - Nursing assessment/ re-assessments and notes - Physician orders - Physician notes - Assessments/evaluations and progress notes from all professional disciplines as appropriate. - Medication and treatment records as applicable - Lab reports, as applicable	- Are all resident's needs/problems identified? - Is the plan developed to meet these needs? - Does the plan demonstrate an interdisciplinary approach, and include: *Short & long term goals *Goals stated in measurable/observable terms *Approaches (staff action) to meet the resident action goals *Responsible disciplines/staff responsible for approach/approaches to assist resident in achieving goal/goals - Is plan being re-assessed and changed as needed to reflect current status? - Does plan of care accurately reflect information gained from observation, interview and record review?	PHYSICIAN SERVICES 405.1121 442.346 MEDICAL RECORDS 405.1132 442.318 RESIDENT RIGHTS 405.1121 (k) 442.311 24 HOUR NURSING SERVICE 405.1124 442.338 SPECIALIZED REHABILITATION SERVICES 405.1126 447.343 TRAINING 405.1121 (h) 442.314 RESIDENT ROOMS 405.1134 (e) 442.325 442.326 INFECTION CONTROL 405.1135 442.328 442.324

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SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
dents' (with residents/family input if applicable) needs through the coordinated efforts of all disciplines.		- Who is Resident Care Coordinator for identified resident? - Is the plan of care useful to you in caring for the resident? - Is there anything the resident needs that is not addressed in the plan of care? - How often is it reassessed?			SOCIAL SERVICES 405.1130 405.1130 (a) 442.344 (d) ACTIVITIES 405.1131 442.345 DIETETIC SERVICES 442.1135 442.332

LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
TRAINING F241 SNF 405.1121(h) F242 ICF 442.314 F243 1. Facility staff are knowledgable about the problems and needs of the aged, ill, and disabled. F244 2. Facility staff practices proper techniques in providing care to the aged ill and diseased F245 3. Facility staff practice proper technique for prevention and safety, accident prevention , confidentiality of resident information, and preservation of resident dignify including protection of privacy and personal and property rights.	How do staff relate to residents? Does the facility reflect adaptations for the elderly, i.e., information given in large print, floors covered with materials that allow for ease of movement with walkers, wheel chairs, etc.? Is resident care given using accepted professional standards? Is privacy maintained during bathing treatment, toileting.	Ask Residents o Does staff know how to take care of you? o What things do they do to help you accommodate your (poor vision, unsteady walking, arthritis, etc.) Ask Staff o What, if any, training have you had here to learn about unique problems and needs of the aged? o What training have you had during the last 12 months. o How have you learned about facility policies and procedures? o Does the facility ask your needs when they develop a training program? o In what areas would you like to have training?	Care plans reflect staff's knowledge of the problems and needs of the residents and special adaptations that are needed. Progress notes indicate that the special needs are considered in implementing planned care.	Facility staff adjusts care to needs/problems of resident. Staff is knowledgeable concerning facility policies and procedures. Staff practices correct techniques i.e., infection control rehabilitation nursing techniques, etc. Staff interacts and treats residnets in a kind, caring way	Residents Rights SNF 405.1121(b) ICF 442.311 Infection Control 405.1135 (a)(b)(c) (d)(e) 442.327(b) Physical Environment 405.1134(a) 442.315(b) (c) 442.326(a) (c) Nursing Services 405.1124 (c)(a)(e) 442.318 (a)(2) Social Services 405.1130(a)

INTENT: To assure that facility provides ongoing training to staff so that they will be knowledgeable in current practices, use proper techniques, and interact with residents in a kind, carring way

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LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
MEDICAL RECORDS F246 SNF (405.1132)				All information required is present in the record.	
Content F247 SNF (405.1132 (c))					
F248 ICF 442.318(a)(c)					
F249 1. The medical record contains sufficient information to identify the resident clearly to justify diagnoses and treatment and to document results accurately.					
2. The medical record contains the following information:					
F250 a. Identification Information					
F251 b. Admission data including past medical social history					
F252 c. Transfer form, discharge summary from any transferring facility					

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LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
F253 d. Report of resident's attending physician					
F254 e. Report of physical examinations					
F255 f. Reports of physicians periodic evaluations and progress notes					
F256 g. Diagnostic reports and therapeutic orders					
F257 h. Reports of treatments					
F258 i. Medications administered					
F258 j. An overall plan of care setting forth goals to be accomplished through each service's designed activities, therapies and treatments					
F260 k. Assessments and goals of each service's plan of care					

LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
F261 1. Treatments and services rendered					
F262 m. Progress notes					
F263 n. All symptoms and other indicitations of illness or injury including date, time and action taken regarding each problem.					
INTENT Brings together all resident information. Reflects the care being given to the residents and helps all care givers to make decisions on care needed.					

LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
TRANSFER AGREEMENT F264 SNF (405.1133)		**ASK STAFF:** o What is the routine information you provide to a new facility when you transfer a resident?	Review information on medical record of resident who was temporarily transferred and is again back in the facility.	All pertinent resident information must be documented on the medical record at the time of transfer.	Patient Rights 404.1121(k) 442.311
F265 SNF (405.1133 (a))		o Who provides this?	Look at physician and nursing progress notes of above residents to determine if the timeliness of transfer was consistent with accepted standards of care.	The resident was not injured in any way by a delay in the transfer process.	
F266 ICF (442.316)			Does facility have an agreement with a hospital? Not required if hospital under same ownership, direction and in same campus.		
F267 A. Whenever the physician determines that a transfer is medically appropriate between a hospital or a facility providing more specialized care and the nursing facility, admission to the new facility shall be effected in a timely manner.			Is transfer form complete with all data, with appropriate signatures? Does the medical record indicate that adequate and pertinent aspects of the discharge planning portion of the patient care plan accompany the patient on transfer?		
F268 B. Information necessary for providing care and treatment to transferred individuals is provided.					

LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
F 269 Physical Environment 405.1134					
F 270 A. Nursing Unit 405.1134(d) F 271 1. Unit properly equipped for preparation and storage of drugs and biologicals. F 272 2. Utility and storage rooms are adequate size. F 273 4. The unit is equipped to register resident calls with a functioning communications system from resident areas including rooms and toilets and bathing facility	There is adequate light to prepare medications. There is sufficient space to prepare medications for administration in a safe and effective manner. There is sufficient space for storage of medications. Unit dose carts are protected from tampering and theft. Medication cabinets lock. Refrigeration facilities are available for medication There is sufficient storage space for I.V. fluids. Handwashing faciliare readily accessable either in the medication preparation area or adjacent to it. Audible call system is on and working. Long cords are available for chair bound patients.	Ask Nursing Staff: o What do you use the medication room (area) for? o Where is the handwashing sink? o Do you have enough, convienient storage area for I.V. fluids and medications needing refrigeration? o Where are the keys for the medication room and unit dose carts? o Do you feel you have adequate storage space for supplies and equipment? o If no, what problems does that cause? o Does the resident call system function properly? Ask Residents: o Do the call bells in your room and in the toilets and bathing areas always work? o If no: - How often is it that they do not work? - How long does it take to get them fixed?		Medication preparation and storage areas provide adequate space and light to prepare medication and to store medication and needed supplies. Light is provided where the unit dose cart is in use. A medication refrigerator is available and does not contain patient or employee snacks. Juice, etc. used in administer-medication is allowed. Clean and dirty areas must be separated, preferably in separate rooms. Storage space must be available for bulky items and supplies so that they can be stored without blocking corridors and exits. Medications are protected from unauthorized use. All call bells must be in working order and must be present in all resident bedrooms, toilets and bathing areas. Audible signals, if in the system, must be in working order and turned on.	Nursing Service 405.1124 g 442.337 Infection Control 405.1135 Governing Body 442.325

LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
B. Dining and Activities Area F 274 F 275 405.1134(g) 442.329	Area is clean and well maintained. There is sufficient space between tables to allow for safe passage of wheelchairs and residents with walkers, canes and other assistive devices.	**Ask Residents**: o Is there enough room between tables to allow you to feel safe in getting to your table? o Can you sit comfortably in your wheelchair at the table? o How is the lighting and ventilation level for you? o Are sitting preferences permitted?		Regulations clearly set out conditions for compliance. Refer to the regulations.	Dietetic Services 405.1125 442.331 Patient Activities 405.1131 442.345
F 276 1. The facility provides one or more clean, orderly, and appropriately furnished rooms of adequate size, designed for resident dining and resident activities.	Table height or design allows residents in wheelchairs to sit a normal distance from the table.				
F 277 2. Dining and activity rooms are well lighted and ventilated.	Lighting and ventilation in the dining/activity areas is provided according to recommended standards.				
F 278 3. Any multi-purpose room used for dining and resident activities has sufficient space to accommodate all activities and prevent their interference with each other.	A multi-purpose room should not be used for storage of items such as beds, mattresses, boxes, etc.				

LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
F279 405.1134(e) Indicators C&D apply to SNFs					
F280 C. Resident Rooms 442.325	Observe rooms and furnishings for maintenence, cleanliness and safety.	Ask Residents: o Is your room kept clean? Who cleans it? When and how often		Refer to the regulations	Resident Rights 405.1121 (k)(1)(5) (9)(13) 442.311(a) (d)(2) (g)(1)(2) (6) (k) Physical Environment 405.1134(d
F281 1. Single rooms have at least 100 sq. feet.	Look for dust/dirt on lights, high surfaces, under heating units, and in corners. Use a flashlight.	o Is your bed, chair, and other furniture and fixtures kept in good repair?			
F282 2. Multiple resident rooms have no more that 4 residents and at least 80 sq. feet per bed.	Are beds, lights, plumbing all in working order? Observe for all regulatory requirements as noted to the left.	o Do you feel you have enough privacy? o What personal belongings are you allowed to have? o Is the lighting in your room sufficient for you?			
F 283 3. Each room is equipped with or convenientl located near toilet and bathing facilities.	Are privacy curtains present, sufficient length and width, and clean?	o Is your chair comfortable? o			
F 284 4. There is a capability of maintaining privacy in each.	Test several call lights. Are call lights within reach, including emergency lights in toilets and bathing areas?				
F 285 5. There is adaquate storage space for each resident.	What is the ratio of residents to toilets and showers				
F 286 6. There is a comfortable and functioning bed and chair, plus a functioning	What personal belongings do residents have in their rooms? Is there				

LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
cabinet and light.	sufficient storage for their belongings?				
F 287 7. Personal expression is allowed.	Can a stretcher be wheeled beside the bed without moving furniture?				
F 288 8. The resident call system functions in resident rooms.					
F 289 9. Each roonm is designed and equiped for adequate nursing care and the comfort and privacy of residents.					
F 290 10. Each room is at or above grade level.					
F 291 11. Each room has direct access to a corridor and outside exposure					
Exception: Not required for ICF residents.					

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LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
D. Toilet and Bath Facilities F 292 442.326					
1. Facilities are clean, sanitary and free of odors. F 293 2. Facilities have safe and comfortable hot water temperatures. F 295 3. Facilities have the capability of maintaining privacy. F 296 4. Facilities have grab bars and other safeguards against slipping. F 297 5. Facilities have fixtures in good condition.	Are there adequate numbers of toilets, baths and showers for the residents tjat are accessable to, and functional for all residents? Are these conviently located in or near resident rooms Check for water on floors of bath and shower rooms. Is privacy provided Are facilities clean, sanitary and free of unpleasant odors? Are bathrooms equipped with soap, toilet tissue, towels, etc. Hot water is between 110-120 degrees or the acceptable State level. Hot water temperature control must be maintained. Note also condition of grab bars, plumbing and fixtures.	Ask Residents: o When was your last bath? The one before? o Do you feel safe getting into and out of the bathtub? o If equipment is needed to get in and out of the tub, do you feel safe with it? o Does your wheelchair fit into the toilet or bathroom?	Bathing schedule for patients in your indepthreview.	Privacy is maintained for residents in toilet and bathing areas. Toilet and bathing areas are clean. Water is removed from floors immediately upon completion of bathing. Hot water is within the acceptable temperature range. Soap, toilet paper and towels are available in the bathrooms. Grab bars are present and securely fastened to the wall. Ventilation and lighting systems are correctly functioning. Plumbing and other fixtures are in good condition.	

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LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
F. Social Service Area F 298, 299 405.1130 (b) 442.344 F 300 1. Capability to assure privacy for interviewing F 301 2. Adequate space for clerical and interviewing functions. F 302 3. Easily accessible to residents and staff.	Does the social worker have a locked file available? Where are social service interviews and meetings with clergy held? Are rooms in areas easily accessable to residents?	Ask Resident: o Does the social worker see you in a private room or in your own room? o If in your own room, do you feel that you have enough privacy?		Refer to regulations	
F. Therapy Areas F 303 405.1126 a F 304 442.328(a) F305 1. Space is adequate for proper use of equipment by all residents receiving treatment.	Therapy areas are accessable to all residents needing the facilities. Space allows for safe maneuvering of residents and equipment and staff. All residents are able to be observed and supervised during therapy. Equipment has indication (stickers, etc.) to indicate proper maintenence. All equipment fastened to floor and walls is secure.	Ask Resident: o Do you feel that the equipment you use is safe? o Do you have enough room for your treatment? Ask Therapy Staff: o Is your equipment adequately maintained? o Do you have enough room to safely and adequately provide treatment?	Refer to Regulations		

LONG TERM CARE SURVEY

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SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
G. Facilities for special care F307 405.1134(f) F308 442.328(b) F309 1. Single rooms with private toilet and hand-washing facilities are available for isolating residents. F310 2. Precautionary signs are used to identify these rooms when in use.	Are private rooms available that meet regulatory criteria If a resident is in isolation, are precautionary signs posted, and are they legible and understandable?	Ask Supervisory personnel: o What room(s) do you use for isolation? o What is your procedure is the room is already occupied when you need it for isolation? o Will you show me the signs you use to identify the isolation room?		Rooms meeting the regulatory requirements are available in the facility. There is a procedure that is implemented when an isolation room is needed, but it is already occupied. Isolation signs are visable and clearly convey their intended message?	Resident Rights 405.1121(k (4) 442.311(c) (2) Infection Control 405.1135(b

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
H. Common Resident Areas F311 SNF 405.1134(j) F312 ICF 442.324 F313 1. All common resident areas are clean, sanitary and free of odors. F314 2. Provision is made for adequate and comfortable lighting levels in all areas. F315 3. There is limitation of sounds at comfort levels. F316 4. A comfortable room temperature is maintained. F317 5. There is adequate ventilation thru windows or mechanical measures or a combination of both. F318 6. Corridors are equipped with firmly secured handrails on each side.	Use senses - sight, hearing, olfactory when surveying common areas as lounges, lobby, corridors. Note levels of lighting for both reading and non-reading areas. Is it bright enough but without glare? Are areas clean and without offensive odors? Do background sound levels allow for ease of communication and comfort for residents/visitors? Do residents seem comfortable with the room temperature - note the use of several layers of clothing, many residents fanning themselves, etc. Are handrails on each side of the corridor and are they secure?	Ask Residents: -Do you think that the lounges and corridors are usually clean? -Do they have any unpleasant odors? -Is the lighting level comfortable for you to read? Is it adequate for you to feel safe walking? -Do you have any difficulty with the noise level? -Is the temperature usually comfortable for you? -Do you feel there is adequate ventilation? -Are there handrails in all of the corridors? -Are they securely fastened to the wall? Ask Superivosry Staff: -If there is a water main break or other interruption in the water supply, how do you obtain water for essential areas and duties?		-Floors and furniture should appear clean - free of grass contamination. -Residents should have lighting bright enough to safely negotiate corridors, lounges, etc. and in reading area, be bright enough to read. But the brightness should be free of glare. Remember, the elderly need a higher level of lighting as their sight diminishes. -Except for times when a louder level of sound is necessary for communication, sounds should be unobtrusive and "comfortable". -Room temperature comfort levels vary widely, and in general the elderly will require a higher temperature for comfort than younger people. Use information from resident interviews and your observations to determine if the temperature is "comfortable" for most residents. -All corridors in resident-used areas are equipped with handrails on each side. These rails securely fastened to provide the residents with a firm support. -Supervisory staff are able to tell you how they will obtain water for drinking, clearing/bathing of residents, and other essential functions if their normal water supply is interrupted.	Infection Control 405.1135 (i)

LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
F319 7. Staff are aware of procedures to ensure water to all essential areas in the event of less of normal supply.					

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LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
F320 I. Maintenance of Building and Equipment SNF 405.1134(i) F321 1. The interior and exterior of the building are clean and orderly. F322 2. All essential mechanical and electrical equipment is maintained in safe operating condition. F323 3. Sufficient storage space is available and used for equipment to ensure that the facility is orderly and safe. F324 4. Resident care equipment is clean and maintained in safe operating condition.	-Ceiling and floor tile in good condition -Paint in good repair -No holes in walls -Look for rat and other rodent trails outside and inside -Preventive maintenance program for all equipment is followed -Wheelchairs not stored in hallways, bathrooms, etc. -Window screens are in good repair -Check overbed tables, wheelchairs, etc. for cleanliness and operation	Ask Staff: -How many housekeeping staff are available? -How late are housekeepers on duty? -What about weekends?			Physical Environment 405.1134 (d)

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LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
Indicators J&K apply to ICFs. F326 Dietetic Service Area 405.1134(h) F327 1. Kitchen and dietetic service areas are adequate to insure proper, timely food service for all patients. F328 2. Kitchen areas are properly ventilated, arranged, and equipped for storage and preparation of food as well as for dish and utensil cleaning, and refuse storage and removal.	Observe for" - needed space to carry out routine operations. - maintenance of working surfaces equipment, utensils, and serving dishes. - operable dish machine - 3-sink method of pot/dish washing properly carried out. - operable and clean exaust fan - stored dishes and pots are free of baked-on food particles and chips. - food stored off floor. - protective covers for florescent lights - handwashing sink readily accessible.	Ask Staff: o What have you been trained to do? o What type of dishmachine do you have? How does it operate?	Dishwasher wash cycle 150-160 degree, dishwashing rinse cycle 180 degrees. A lower temperature rinse cycle is permissible if using sanitizing or thermopaper, or manufacture's recommendations.		Dietetic Services 405.1125 (g) 442.331(b)

LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
K. Dietetic Sanitary Conditions F329 405.1125(f)(g) F330 1. Dietetic personnel practice hygienic food handling techniques. F331 2. Food is stored, refrigerated, prepared, distributed, and served under sanitary conditions. F332 3. Waste is disposed of properly.	Observe the following: -cleanliness of hands, fingernails, hair, clothing. -use of hair restraint. -whether employees wash hands with soap and water after using the toilet, smoking, blowing their nose, touching raw meat, poultry or eggs -employees using hands to mix food when utinsils could be used. - employees using the same spoon more than once for tasting food while preparing, cooking, or serving. Verify that: -hot foods are 140 degrees or above -cold foods are below 45 degrees or lower (*note: food held for more than 2-3 hours between 60 and 125 degrees may not be safe to eat) -cooked meats held longer than that 3 days is put in	Ask Staff: o What happens when you report to work with a cold? A cut or sore on your hand? o Where is handwashing sink for dietary staff? o Do you use plastic hand covers (disposable)? If so, when? o Where are your serving utensils located? o What are temperatures for the refrigerators and freezers? Who is responsible for checking temperatures? o Do you have thermometers to check water and food temperatures? (ask them to demonstrate how they take temperatures)			Dietetic Services 405.1125 (e)(f)(g)

LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
	the freezer				
	-food does not have an"off" or bad odor.				
	-refrigerated food is not moldy or slimy.				
	-cracked eggs are only used in foods to be thoroughly cooked				
	Observe that waste is in covered containers, bagged and tied for disposal, and that dumpsters are covered				

LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
1. Emergency Power F333 405.1134(b)	Is an emergency generator available			As per regulations	
F334 1. An emergency source of electrical power necessary to protect the health and safety of residents is available.	Test generator under full load conditions Check items on emergency power: -lighting -fire detection -alarms -extinguishing systems -life support systems				
F335 2. Emergency power is adequate at least for lighting in all means of egress; equipment to maintain fire detection, alarm, and extinguishing systems; and life support systems.	Transfer time from normal power to emergency power to occur within 10 seconds. Check for grounded extension cords at nurses station. Batteries and 2 - ? lights work				
F336 3. Emergency power is provided by an emergency generator located on the premises where life support systems are used	Where are emergency outlets?				

LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
Infection Control F337 SNF 405.1135 F338 A. Infection Control SNF (405.1135 (b)) F339 Aseptic & isolation techniques are followed by all personnel. B. Sanitation F340 SNF 405.1135(c) F341 The facility maintains a safe, clean, and orderly interior. C. Linen F342 SNF 405.1135(d) F343 ICF 442.327 F344 1. The facility has available at all times a quantity of linen essential for proper care and comfort of residents. F345 2. Linens are handled; stored, processed, and transported in such a manner as to prevent the spread of infection.	-Observation of dressings technique to identify if infection control principles are being adhered to: -sterile technique -sterile/clean field -disposal of dressing -handwashing -use of gloves -Observation of isolation precautions: -signs -linen, double bagged -soiled linen, doubled bagged -gowns/masks -gloves -handwashing -disposable dishes -information for visitors -Procedures followed by: -Laundry -Housekeeping -How is dirty linen transported to laundry or holding area? -Do aides wash hands after cleaning up dirty linen? -How do aides handle clean/dirty linen while changing beds? -Look for evidence of insect or rodent presence (mouse or rat droppings,	Ask Staff -What type of dressings are you performing? -How often are dressings changed? -Why is resident on isolation/precautions? -Do laundry/housekeeping personnel/aides know procedures? Ask Resident -Do you know why you have dressings? -Do you know why you are on isolation/precautions? -Do you have clean linen when you need it? Ask Staff -Have you seen insects (roaches, flies, etc.)? -Have you seen rodents and/or droppings?	Review records of residents selected for indepth review for infection.	Compliance will be based mainly on your observations. Deficiencies will be cited if you see: oSignificant breaks in aseptic or isolation technique oClutter or unclean conditions that would cause unsafe conditions oInadequate supplies of linen to provide proper care and comfort for residents oPoor techniques for handling clean and dirty linen oEvidence of insect or rodent infestation oUse flashlight to check for roaches in closets, cabinets	Nursing Services 405.1124 442.338

LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
D. Pest Control F346 SNF 405.1135(b) F347 1. The facility is maintained free from insects and rodents.	roaches, flies around trash -Screen doors closed -Windows that can be opened have screens that are in good repair				

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LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
DISASTER PREPAREDNESS F348 SNF(405.1136) F349 SNF(405.1136(a)) F350 ICF(442.313) Indicators A and B apply to ICFs. A. Disaster Plan F351 1. Facility staff are aware of plans, procedures to be followed for fire, explosion or other disaster. F352 2. Facility staff are knowledgeable about evacuation routes. F353 3. Facility staff are aware of their specific responsibilities in regard to evaluation and protection of residents. F354 4. Facility staff are aware of methods of containing fire.	-Disaster plan is located at each nursing station -Evacuation plans posted in each smoke compartment	**ASK RESIDENTS:** -Do you know what to do in case of fire? -How often do you rehearse it? **ASK STAFF:** -What are your responsibilities at a fire drill? -What is the facilities disaster plan? (Specify types) -Have you undergone disaster training? -Have you participated in a fire disaster drill? When? -How frequently are drills held? -Have you been trained/instructed in the use of fire equipment, fire containment methods? -Have you been trained in transfer of casualties and records? -Do you know the evacuation routes? -How would staff meet emotional needs of residents during/following a "disaster", e.g., fire		A disaster plan is available and facility staff know their roles. -Minimum of 12 fire drills per year (1 fire drill per shift on a quarterly basis) Drills should not be at change of shift as facility would not usually have two shifts present if a fire occurred. -One disaster drill per year.	**Physical Environment** 405.1134 (a)(b) 442.321 **Administration** 442.314

LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	DETERMINING COMPLIANCE	CROSS REFERENCE
B. Drills F355 SNF(405.1136 (b)) F356 1. All employees are trained, as part of their employment orientation in all aspects of preparedness for any disaster. F357 2. Facility staff participate in ongoing training and drills in all procedures so that each employee promptly and correctly carries out a specific role in case of a disaster. Intent To insure a clean, safe environment for residents.					

[COMMITTEE STAFF NOTE: This Request for Services changes the list of regulatory requirements identified by HCFA as "Critical Requirements" (CRs)]

Recd 10-30-86

Control #585

REQUEST FOR SERVICES

1. TO
Charlie O'Neill BDMS/OHPS

2. REQUESTED BY
Mike Moran, Acting Director, DDPA, OSC

3. DATE OF REQUEST
10-29-86

4. LIAISON REPRESENTATIVE
Carol Gorschboth CG

5. EXTENSION
43432

6. REQ. COMPLETION DATE
ASAP

7. SUBJECT OF REQUEST
Modification to the Critical Requirements (CRs) for SNF and ICFs - Correction

8. DESCRIPTION/JUSTIFICATION OF REQUEST

This replaces the service request dated 10-15-86 (see attached). The list of tags for SNFs is amended to include additional CRs that apply to both SNFs and ICFs. The lists were also revised to identify the statutory requirements and to present the tags in numerical sequence.

XX ATTACHMENT

EVALUATION BY SERVICING ORGANIZATION

9. PROJECT TITLE

10. PROJECT NUMBER

11. PROJECT MANAGER

12. EXTENSION

13. LEAD COMPONENT

14. ☐ APPROVED ☐ APPROVED DEFERRED ☐ REJECTED

15. COMMITMENT DATE

IF NOT APPROVED, REASON FOR REJECTION

16. APPROVING OFFICER

FORM SSA-3893 [illegible]

REQUEST FOR SERVICES

1. TO
Charlie O'Neill   BDMS/OHPS

2. REQUESTED BY
Mike Moran   HSQB/OSC

3. DATE OF REQUEST
10/15/86

4. LIAISON REPRESENTATIVE
Carol Gorschboth

5. EXTENSION
4-3432

6. REQ. COMPLETION DATE
11/14/86

7. SUBJECT OF REQUEST
Modification of the Critical Requirements for SNFs and ICFs

Replaced by 10/29 request

8. DESCRIPTION JUSTIFICATION OF REQUEST

Attached are the new critical requirements (CRs) for SNFs and ICFs which will replace the list of CRs originally submitted in the PaCS specification package dated February 12, 1986. Modify the Data Element Description, annotate the SRF Dictionary and revise the RADARS CR deficiency counters to include the new CRs. In addition, modify the Individual Facility Profile, Table 13, to identify any of these data tags that may come in as flagged (#).

cc: Stan Zacharkiw
Bob Young

☒ ATTACHMENT

EVALUATION BY SERVICING ORGANIZATION

9. PROJECT TITLE

10. PROJECT NUMBER

11. PROJECT MANAGER

12. EXTENSION

13. LEAD COMPONENT

14. ☐ APPROVED ☐ APPROVED DEFERRED ☐ REJECTED

15. COMMITMENT DATE

IF NOT APPROVED, REASON FOR REJECTION

16. APPROVING OFFICER

Skilled Nursing Facilities (L007=02, 03, 04) Provider Group 2
(Freestanding, SNF/ICF Distinct Parts and Dually Certified)

CRs

Data Tag	Description
F42	SNF-Residents Rights
F43	ICF-Residents Rights
F63 (S)	Complete Accounting of Resident Funds
F68 (S)	Receipts for Residents' Disbursements
F69 (S)	Financial Record Readily Available
F70 (S)	Free From Mental and Physical Abuse
F71 (S)	Authorized Use of Restraints
F86	Delegation of Rights and Responsibilities
F96(S)	SNF-Resident Supervision By Physician
F97(S)	ICF-Resident Supervision By Physician
F109 (S)	Emergency Services
F112	ICF-Nursing Services
F113 (S)	24-Hour Nursing Services
F155	Rehabilitative Nursing Care
F166 (S)	SNF-Administration of Drugs
F167	ICF-Administration of Drugs
F172 (S)	SNF-Conformance With Physicians Drug Orders
F173	ICF-Conformance With Physicians Drug Orders
F176	SNF-Menus and Nutritional Adequacy
F177	ICF-Menus and Nutritional Adequacy
F179	SNF-Therapeutic Diets
F191	SNF-Frequency of Meals

Skilled Nursing Facilities (L007=02, 03, 04) Provider Group 2
(Freestanding, SNF/ICF Distinct Parts and Dually Certified)

CRs

Data Tag	Description
F192	ICF-Frequency of Meals
F265 (S)	Patient Transfer
F267 (S)	Transfer to Another Facility
F268 (S)	Interchange of Information
F329	Dietary Sanitary Conditions
F342	SNF-Linen
F343	ICF-Linen
F349	SNF-Disaster Plan
F350	ICF-Disaster Plan
K9=B	Life Safety Code Compliance
L12=A,A1,B	Health and/or Life Safety Code Waivers

CR Total = 33

(S) = Statutory Requirement

Revised 10-29-86

Intermediate Care Facilities (L007 = 10) Provider Group 2
(Freestanding and Distinct Parts of Hospital)

CRs

Data Tag	Description
F43	ICF-Residents Rights
F63 (S)	Complete Accounting of Resident Funds
F68 (S)	Receipts for Residents' Disbursements
F69 (S)	Financial Record Readily Available
F70 (S)	Free From Mental and Physical Abuse
F71 (S)	Authorized Use of Restraints
F86	Delegation of Rights and Responsibilities
F97 (S)	ICF-Resident Supervision By Physician
F112	ICF-Nursing Services
F167	ICF-Administration of Drugs
F173	ICF-Conformance With Physicians Drug Orders
F177	ICF-Menus and Nutritional Adequacy
F192	ICF-Frequency of Meals
F267 (S)	Transfer to Another Facility
F268 (S)	Interchange of Information
F343	ICF-Linen
F350	ICF-Disaster Plan
K9=B	Life Safety Code Compliance
L12≠A,A1,B	Health and/or Life Safety Code Waivers

CR Total = 19

(S) = Statutory Requirement

Revised 10-29-86

[COMMITTEE STAFF NOTE: This document has been excerpted for brevity.]

state operations manual
Provider Certification

Department of Health
and Human Services

Health Care Financing
Administration

Transmittal No 192 Date NOVEMBER 1986

REVISED MATERIAL	REVISED PAGES	REPLACED PAGES
Section 2764 (Cont.)	2-161 - 2-164 (4 pp.)	2-161 - 2-164 (4 pp.)
Table of Contents, Part Three	3-1 - 3-2 (2 pp.)	3-1 - 3-2 (2pp.)
Sections 3005 - 3006 (Cont.)	3-5.2 - 3.5.10 (9 pp.)	3-5.2 - 3-5.8 (7 pp.)
Section 3020 (Cont.)	3-11 - 3-12 (2 pp.)	3-11 - 3-12 (2 pp.)
Sections 3036 - 3052	3-14.1 - 3-18 (8 pp.)	3-15 - 3-18 (4 pp.)
Exhibit 16	5-95 - 5-96 (2pp.)	5-95 - 5-96 (2pp.)
Exhibits 39-40	5-161 - 5-162 (2 pp.)	5-161 - 5-162 (2 pp.)
Exhibits 63	5-236.1 - 236.2 (2 pp.)	---

NEW PROCEDURE--EFFECTIVE DATE: December 3, 1986

This issuance contains procedures for the denial of payments for new SNF admissions as an intermediate sanction when a recertified SNF is not in compliance but the deficiencies do not present immediate jeopardy to the health and safety of patients. In such cases, a denial of payments is usually preferable to nonrenewal, cancellation or prompt termination of the provider agreement.

When a SNF is certified not in compliance, the RO decides whether to use this sanction or to terminate, nonrenew or cancel. HCFA expects that State Medicaid agencies will adopt the same procedures for Medicaid-only SNFs and ICFs.

Section 2764, Completion Instructions for the Certification and Transmittal, HCFA-1539.--This section includes notations to be made on the HCFA-1539 for resurveys during a denial of payments.

Section 3005, Basis for Terminating Provider Participation--Citations and Discussion.--This section is modified to explain that after the SA uses criteria to recommend either termination of a long-term care facility or to use the denial of payments for new admissions, the RO, or the State Medicaid agency if appropriate, makes an independent choice as to which sanction to employ. When the RO makes a choice for a SNF participating in both Medicare and Medicaid, it is binding on the Medicaid agency.

Section 3006, Denial of Payments in Lieu of Termination of Long-Term Care Facility.--This section explains circumstances under which the denial of payments can be used. It further explains that the effect on patients being readmitted is unaffected by a State's reserved bed policy, and that patients returning from temporary leave are not considered readmissions. Patients discharged during the sanction period can be readmitted during that period without restriction. In addition, this section explains how invoking the denial of payments automatically extends the life of the time-limited agreement for the duration of the denial of payments.

Section 3020, Nonrenewal or Cancellation of Time-Limited Agreements for Long-Term Care Facilities.--This section notes that if the denial of payments is available, its use is generally preferred over nonrenewal, cancellation or termination, and that it effectively defers the RO's final decision on compliance for eleven months.

Section 3036, Procedures for Denying Payments for New Admissions.--This section contains the timetable and procedures for imposing and rescinding the denial of payments and for conducting credible allegation and recertification resurveys during the period of the denial of payments.

Section 3045, Appeals of Adverse Actions for Medicaid Skilled Nursing and Intermediate Care Facilities.--The facility is entitled to an informal hearing before the denial of payments is imposed. Although termed "informal," this hearing entails accepting evidence and rendering a written determination. Nevertheless, it is a separate and different process from the reconsideration or evidentiary hearing afforded for other due process appeals. Section 3045 is an informational section requiring no SA action.

Exhibit 16, Model Letter to Psychiatric Hospital Requesting Data for Presurvey Review by HCFA Surveyors.--This exhibit has been rewritten to refer to HCFA surveyors, because NIMH consultants are no longer regularly used to assist in surveys of psychiatric hospitals.

Exhibit 40, Model Letter Notifying Skilled Nursing Facility of Noncompliance.--The title of this letter previously referred to notifying a SNF of its deficiencies, but the letter is actually used in noncompliance situations; hence the change in title. An alternative paragraph is now given so that the letter can be adapted depending on whether the SNF meets or does not meet the §3006 criteria to be eligible for a denial of payments for new admissions. The letter has also been revised to include a request for a plan of correction.

Exhibit 63, List of Documents in Certification Packets.--The exhibit lists the contents of certification packets forwarded during a denial of payments.

3005. BASIS FOR TERMINATING PROVIDER PARTICIPATION--CITATIONS AND DISCUSSION

A. Medicare Provider Agreements.--Provider agreements and agreements with clinics as to the provision of outpatient physical therapy are terminated by the RO under the authority of section 1866(b) of the Act. 42 CFR 489.52-489.57 set forth the rules for terminating agreements. Medicare providers (as defined in §2002) must substantially meet each of the applicable Conditions of Participation.

B. Termination of Coverage of Supplier Services Subject to Certification.--Sections 1832(a), 1861(p) and (s), and 1881(b) of the Act authorize the Secretary to establish various Conditions for Coverage of supplier services, and thus impliedly authorize determinations that the Conditions cease to be met. Regulations (42 CFR 405.1502(b)) provide that the Secretary will make findings, setting forth pertinent facts and conclusions, and an initial determination as to whether or not a supplier meets the respective Conditions for Coverage. The determination can be made as a result of a written request by the supplier to start or expand services, or to establish that a supplier continues to meet respective Conditions for Coverage. An adverse determination may involve one or more areas of services offered by a supplier. Reimbursement for the services involved in the adverse determination ceases immediately. While these adverse determinations are not referred to in the regulations as "terminations," their effect on reimbursement for the supplier's services is the same as when a provider agreement is terminated. Procedures for certifying supplier noncompliance are parallel to those for certifying provider noncompliance.

The agreement which an ambulatory surgical center (ASC) or rural health clinic (RHC) enters into is a category specific agreement and not a provider agreement. It is the coverage of ASC or RHC services that is terminated, not the agreement.

C. Termination of Medicaid Participation

1. Medicaid Only Long-Term Care Facilities.--If deficiencies do not present an immediate jeopardy to patients' health and safety, the State Medicaid agency has the option to deny payments of new admissions under the authority of section 1902(i) of the Act, or invoke termination. The State Medicaid agency is not required to adhere to your recommendation as to whether to terminate or to deny payments for new admissions.

2. Medicare/Medicaid Long-Term Facilities.--For dually certified SNFs, the HCFA decision to deny payments for new admissions is binding on the Medicaid State agency; the State must deny payments for admissions effective the same date as the denial of payments for Medicare admissions.

3. Other Providers.--The Medicaid agreement must be terminated by the State Medicaid agency when you determine that any provider or supplier other than a long-term care facility does not meet applicable program requirements. Where partial terminations are made, such as for specific laboratory tests, the Medicaid determination must follow suit.

D. Cancellation of Medicaid Agreement by the Secretary..--HCFA has authority under section 1910(c)(2) of the Act to cancel the approval of a SNF or ICF to participate in the Medicaid program when HCFA determines that the facility fails to comply substantially with the Conditions of Participation, 42 CFR 405, Subpart K (SNFs), or with the standards contained in 42 CFR 442, Subparts D, E, F or G (ICFs). In these instances the cancellation is prospective, usually occurring after the provider has had the opportunity for formal hearing before an administrative law judge.

This authority is in addition to the authority under 42 CFR 442.30 which provides that a provider agreement is considered invalid for purposes of providing Federal financial participation (FFP) to the State, unless the State has followed proper procedures; for example, the State Medicaid agency issued the provider agreement even though the SA has not certified the facility as being in compliance. In those instances, the agreement is considered void from its inception, and the State is not entitled to FFP for any of the bills related to the facility.

E. Cause for Termination.--HCFA may terminate provider participation (Medicare providers) if the provider is not complying substantially with the provisions of title XVIII and applicable regulations, or not complying with the provisions of its agreement (42 CFR 489.53). However, certain causes for termination are unrelated to certification and have no impact on the SA. They are:

o The provider places restriction on the persons it will accept for treatment, and it fails either to exempt Medicare beneficiaries from those restrictions or to apply those restrictions to Medicare beneficiaries the same as to all other person seeking care;

o The provider fails to furnish information necessary for HCFA to determine whether or not payments are, or were, due under Medicare and the amount due;

o The provider refuses to permit an examination of its fiscal or other records by, or on behalf of, HCFA as necessary for verification of information furnished as a basis for payment under Medicare;

o The provider has knowingly and willfully made or caused to be made any false statement or representation of a material fact for use in a request for payment under Medicare;

o The provider has submitted, or caused to be submitted, requests for payment under Medicare or amounts for items and services substantially in excess of the costs incurred by providing the items and services;

o The provider has furnished items or services which HCFA determines to be substantially in excess of the needs of individuals or of a quality that fails to meet professionally recognized standards of health care;

o The provider fails to furnish information on business transactions as required;

o The provider fails to disclose information on convicted principals;

o The provider fails to furnish ownership information; or

o The provider fails to comply with civil rights requirements.

Your responsibility is to certify provider compliance with certification requirements. Fiscal intermediaries generally are responsible for dealing with those matters related to reimbursement and coverage. However, in the course of a survey, a surveyor may encounter information which may be indicative of a program abuse or failure to meet other program requirement described in the list above. Communicate these areas of concern to the RO for further action.

F. Termination of Title XIX-Only Skilled Nursing and Intermediate Care Facilities.--Federal Medicaid regulations provide for terminations, nonrenewals, and cancellations, but do not fully describe the implementing procedures. Each State has developed procedures for terminating agreements with SNFs and ICFs when those facilities are not found to be in substantial compliance with program requirements. In any Medicaid-only noncompliance situation, initiate the action, prepare the necessary documents, and forward the documentation to the State Medicaid agency, which has the responsibility for the termination, nonrenewal or cancellation of the Medicaid agreement. In this case, the State Medicaid agency must notify HCFA and the public of its action, and must afford the facility notice and opportunity for a hearing.

Under 42 CFR 431.54(f), the State Medicaid agency may also "lock out" a SNF or ICF for a reasonable period of time if the facility has abused the Medicaid program. This may occur even though the SA has approved the facility. There are no certification instructions directing the SA to participate in "lock out" procedures.

G. Termination Action Based on Onsite Federal Survey.--When immediate and serious threat to patient health and safety is found by a RO survey team whether in the course of a regular scheduled Federal monitoring survey or in response to a complaint, or as part of the JCAH validation effort, the RO initiates termination procedures. Survey findings and factual development are the responsibility of the RO, although you may be asked to assist in documenting or developing aspects of the termination. You, (and the State Medicaid agency, if the provider/supplier also participates in Medicaid) are notified by the RO of the action being taken.

3006. DENIAL OF PAYMENTS IN LIEU OF TERMINATION OF LONG-TERM CARE FACILITY (MEDICARE AND MEDICAID)

A. Authority to Deny Payment for any New Admissions.--Sections 1866(f) and 1902(i) of the Act provide the Secretary and the State Medicaid agency with an alternative to terminating long-term care facilities that fail to meet applicable program requirements. This sanction is the denial of payment for new admissions for a period of approximately 11 months, if the facility's deficiencies do not present an immediate jeopardy to patients' health and safety. There can not be consecutive eleven month periods since at the end of eleven months a decision to continue or terminate participation must be made. However, the eleven month period could be shortened if circumstances change and there is immediate jeopardy to health and safety before eleven months have passed. Alternatively, the RO might rescind the denial of payments in less than eleven months if full compliance is achieved or if the SNF has made significant good faith efforts and progress in achieving compliance. (See §3036.)

The RO has responsibility for denying payments to Medicare SNFs. For dually certified SNFs (Medicare and Medicaid) the RO decision to deny payments is binding for Medicaid also. The State Medicaid agency has authority to deny payments for Medicaid-only SNFs and all ICFs.

B. Cause for Denial of Payments for New Admissions.--A SNF must meet the following criteria before the intermediate sanction can be imposed. The criteria apply to Medicare SNFs, but may be adopted by the State Medicaid agency for Medicaid-only long term care facilities. However, the State Medicaid agency retains the right to establish its own criteria.

- The SNF fails to meet one or more Conditions of Participation;
- The SNF's deficiencies do not pose immediate jeopardy to patients' health and safety;
- The SNF is not cited for a repeat deficiency at the Condition level;
- The SNF was not subject to a denial of payments for new admissions during the previous certification; and
- The SNF indicates in the plan of correction that compliance will be achieved within 11 months from the date the denial of payments is imposed.

If the above criteria are met, follow the procedures set forth in §3036.

C. Effect of Sanction on Patients Discharged and Patients Being Readmitted Following a Temporary Absence From Facility.--The date of formal notification to the facility, not the date on which the denial of payment is imposed, is the controlling factor in determining the effect on the status of patients who have been discharged and those seeking readmission to the facility. The effective date of the sanction is not used in determining the effect on:

- Patients discharged before the date of formal notice. They would be subject to the denial of payments if readmitted.
- Patients going on temporary leave either before or after the date of the notice. They are not considered new admissions.
- Patients discharged on or after the date of formal notice. They are not subject to the denial of payments if readmitted.

D. Status of Time-Limited Agreement During Denial of Payments.--To afford sufficient time to renew an agreement, you survey facilities approximately three months before scheduled expiration of the agreement (§2700D). Should it prove necessary to prevent the agreement from expiring before development is completed, the RO or the State Medicaid agency, as appropriate, can extend the agreement provided there is no immediate jeopardy to health and safety. As long as agreement did not lapse on or before the effective date of denial of payments, the denial of payments automatically extends the life of the agreement for up to eleven full additional months following the month in which the denial of payments becomes effective. The agreement can only be renewed when the denial of payments expires.

In the event of a change of ownership during the extension period, the agreement will be assigned to the successor owner, but the new owner cannot get another agreement unless the facility is found in compliance. The new owner's agreement will go into effect without being delayed by a "reasonable assurance" requirement, when the facility is found in compliance.

3008. PROVIDER/SUPPLIER GIVES NOTIFICATION OF VOLUNTARY TERMINATION (MEDICARE)

A provider or supplier may voluntarily terminate its participation in the Medicare program by notifying HCFA of its intent in writing. If you learn that a provider intends to close its business or wishes to voluntarily terminate:

o Advise the provider to write a letter to the RO notifying it of the intent and the requested date of withdrawal or closure; and

o Submit a HCFA-1539 and any related documentation to the RO.

After receiving notice, the RO will communicate with the provider regarding notification to the public, etc.

The State Medicaid agency notifies the SA and the RO whenever a Medicaid-only SNF or ICF voluntarily terminates its agreement with the State Medicaid agency.

If a voluntary termination is intended to avoid termination for cause, information to that effect should be documented by the SA and RO, retained in the certification file, and considered if the provider requests participation in the future.

3009. PROVIDER/SUPPLIER GIVES NO NOTIFICATION OF GOING OUT OF BUSINESS (MEDICARE)

If a Medicare provider/supplier ceases all business operations, discharges all patients, and refuses new admissions the provider/supplier is considered as voluntarily terminating its agreement or its coverage.

If you learn that a provider/supplier may be going out of business, contact the provider/supplier to verify the situation. Notify the RO immediately to arrange for the public notice which will be published by the RO. The RO sends notice of termination to the provider with copies to the SA, the servicing Social Security office, and the Part A intermediary. The RO sends notice of a supplier going out of business or cessation of Medicare coverage to the supplier, with copies to the SA, the State Medicaid agency, and to those Part B carriers likely to be concerned. Notify the RO immediately if you learn that a provider/supplier has already closed.

3010. TERMINATION PROCEDURES--IMMEDIATE AND SERIOUS THREAT TO PATIENT HEALTH AND SAFETY (MEDICARE)

A. Substantial Noncompliance With Program Requirements Which Pose an Immediate and Serious Threat to Patient Health or Safety.--"Immediate and serious threat" is interpreted as a crisis situation in which the health and safety of patients is at risk. Generally, it is a deficient practice which indicates the operator's inability to furnish safe care and services. An immediate and serious threat to patient health or safety may exist in the presence of one or more of the following (or similar) situations. This list is not to be interpreted as all inclusive, but rather as examples of what HCFA believes may constitute an immediate and serious threat. The surveyor is always expected to describe findings in sufficient detail to show the relative seriousness of the hazard.

o Situations or practices that constitute a serious fire hazard or emergency situation such as:

- Inadequate or faulty emergency power and lighting in the operating, recovery, intensive care, or emergency rooms;

- Bare electrical wiring that presents an immediate fire hazard;

- Blocked or obstructed stairways, hallways and exits which prevent eccess in the event of an emergency;

- Widespread failure to enforce smoking restrictions;

- Failure to maintain required fire protection systems (fire alarm, sprinkler systems) in an operating condition; or

- Failure to maintain the integrity of fire and smoke barriers, such as removal of stairway doors and major unprotected openings in corridor walls.

o Widespread insect or rodent infestation indicative of food contamination or the possible spread of contagion.

o Failure to control infections as evidenced by the presence of facility acquired infections.

o Widespread patterns of patient abuse or poor patient care, including:

- Instances of malnutrition or dehydration that are unrelated to the patient's condition and are a result of poor patient care;

- A pattern of negligence by staff with the result that patients are often left lying in urine, feces or other waste.

- Use of physical or chemical restraints, that are in excess of that which is ordered by a physician.

o Drug or pharmaceutical hazards that directly affect patient health and safety, such as:

- Widespread drug errors, mishandling of drugs or other patient related pharmacy problems;

- Failure to provide medications as prescribed;

- Failure to monitor drugs as evidenced by lack of ordered laboratory work, failure to take vital signs as indicated by drug regimen, and lack of other nursing monitoring practices;

- Gross mishandling of drugs such as leaving drug trays unattended and available to patients and visitors;

- Administration of drugs by unqualified staff; or

- Administration of experimental drugs without the informed consent of the patient (or responsible party).

o Inadequate procedures for procurement, safekeeping and transfusion of blood and blood products that could jeopardize patient health and safety.

o Excessive hot or cold temperatures in patient care areas of facility to the extent that patients are experiencing signs of hyper or hypothermia and the provider/supplier does not have a short term and effective plan for ameliorating these temperatures.

o A pattern of delivering services to patients when the daily care needs of the patients exceed the provider's/supplier's capacity to give care. For example, accepting patients requiring total parenteral nutrition through subclavian catheters when the provider lacks policies and procedures for this specialized care, nursing staff are not knowledgeable about the technology, and essential equipment is not available.

B. Processing of Immediate and Serious Threat Terminations.--When an immediate and serious threat to patient health or safety is documented, complete all termination procedures within 23 calendar days. Processing times given here are the maximum time allowed. Do not postpone or stop the procedure unless compliance is achieved and documented through onsite verification. If there is a credible allegation that the threat or deficiency has been corrected, conduct a resurvey prior to termination if possible. Do not use this procedure if there is a time-limited provider agreement that is subject to cancellation or nonrenewal within 23 days after the survey. In such a case, process the cancellation or nonrenewal as explained in §3020.

1. Date of Survey.--The date of the survey is the date on which the entire survey is completed.

2. Second Working Day.--No later than 2 working days following the survey date:

o Telephone the RO that you are certifying non-compliance and that an immediate and serious threat exists; and o Notify the provider/supplier (by overnight express mail) of it deficiencies, that you are recommending termination to the RO, and that the RO will issue a formal notice (Exhibit 40). The notice will advise the provider/supplier of rights to due proces, the time schedule for the termination action, and that the deficiency must be corrected and the correction verified by you, to halt the termination process. If the provider also participates in Medicaid, notify the State Medicaid agency of your certification.

In the case of a clinical laboratory supplier where non-compliance with a Condition for Coverage is found, send notification to the RO within 2 working days following the survey.

3. Third Working Date.--Forward all supporting documentation to the RO.

4. Fifth Working Day.--The provider/supplier and public will be notified by the RO of the proposed termination action by the most expeditious means available.

in time the survey is to the expiration date or automatic cancellation date, on the seriousness of the deficiencies cited, and on the possibility of instituting a denial of payments for new admissions which effectively defers the reapproval decision for eleven months.

Nonrenewal and cancellation are preferred alternatives to termination if termination would be effective after the projected renewal or automatic cancellation date. If there is no immediate jeopardy to patients' health and safety, a one-time denial of payments for new admissions is usually preferred over nonrenewal, cancellation, or termination.

B. Nonrenewal of Time Limited Agreements.--A nonrenewal is the decision not to renew a TLA following its expiration.

1. Situations Leading to Nonrenewal.--A facility does not qualify for renewal of its agreement if it has been determined, based on resurvey, that:

o The provider has violated the terms of its agreement or the provisions of title XVIII or title XIX, or applicable regulations; or,

o The provider does not substantially meet one or more program requirements (e.g., Conditions of Participation for SNFs and standards for ICFs or ICFs/MR, or has an unacceptable plan of correction); or

o The provider continues to be substantively out of compliance with the same standard(s) (consistently maintains major deficiency) for SFNs, ICFs, or ICFs/MR that were found out of compliance during the last survey on which the current certification period was based.

EXCEPTION: A new period of certification may be approved even though the same standard(s) was out of compliance at the time of resurvey if the deficiencies did not substantially limit the facility's ability to furnish adequate care or adversely affect the health and safety of patients and the provider can document that it achieved compliance during the term of the agreement, but for reasons beyond its control was again out of compliance prior to the expiration of the agreement.

2. Time of Resurvey.--In nonrenewal cases, the provider must be given formal notice of the RO's decision not to enter into a new agreement a full 30 days prior to the date of expiration of its existing agreement. Therefore, complete the recertification survey between 90 and 120 days in advance of the expiration of the term of the agreement. All nonrenewal procedures must be completed by the expiration date of the current agreement.

Process a termination in lieu of nonrenewal if the renewal date is more than:

o 90 days after finding noncompliance, or

o 23 days if you find there is an immediate and serious threat to patient health and safety (Medicare).

3. Facility Does Not Want to Renew.--A participating provider may choose not to renew its agreement. In such cases, it is assumed that the provider's intentions will have been made known in time to permit public notice before the end of the existing agreement. However, there may be cases where a provider will give insufficient notice of its intention not to accept renewal. In these cases, the agreement may have to be extended to prevent hardship to the program beneficiaries being furnished care by the provider.

C. Cancellation of Time Limited Agreements for Long Term Care Facilities.

1. General.--The time-limited agreement may contain an automatic cancellation clause. In this case, you specify a date that is not later than the 60th day following the end of the time period specified for such corrections, and is not later than the end of the ninth month of the agreement. The cancellation clause provides that if the corrections of deficiencies are not made by the date you have specified, or if substantial progress has not be achieved in accordance with an accepted plan of correction, the agreement will automatically terminate on that date. However, if substantial progress is made and an updated plan of correction accepted, the facility may continue to participate. Establish a control on all cancellation clause agreements to ensure that you schedule a verification visit to be performed as soon as possible after the last date specified in the facility's plan of correction. Allow processing time in advance of the cancellation date.

The procedures implementing the cancellation clause are similar to those required for an involuntary termination and as such require comparable development, supporting documentation, and internal clearance action.

However, the basis for invoking this clause may be limited to establishing that the facility has not made substantial progress in carrying out its plan of correction. Whenever a cancellation clause is "invoked" (the 30-day notice is sent) termination action will be taken to remove the facility from participation status. All cancellation procedures must be completed by the cancellation date.

3036 PROCEDURES FOR DENYING PAYMENT FOR NEW ADMISSIONS

A. Timetable.--Employ the following procedures instead of those in §3012 if a Medicare SNF is a candidate for the denial of payments. Since the statutory and regulatory requirements are basically the same for Medicaid-only SNFs and all ICFs, these procedures also may be adopted by the State Medicaid agency for imposing the denial of payments.

1. Date of Survey.--The date of survey is the last day of the onsite survey.

2. Tenth Day.--Mail the HCFA-2567 to the provider requesting a plan of correction within 10 days following the date the facility receives the HCFA-2567. Inform the provider in writing that failure to achieve compliance within 60-90 days from the date of survey could result in termination from the program (Exhibit 40).

3. Twentieth Day.--If compliance has not been credibly alleged by the facility and documented as being achieved, forward your certification of noncompliance to the RO with supporting documentation.

4. Thirtieth Day.--The RO will notify the provider of its decision to terminate or to deny payments, copying the SA and State Medicaid agency. If the decision is to deny payments, the RO will inform the provider that:

o It has the right to an informal hearing before imposition of the denial of payments. If a hearing is desired, the SNF must notify the RO in writing within 5 days of the date of receipt of the notice. The hearing will be held no later than the 40th day after the survey.

o If the decision of the hearing official is adverse to the facility, the denial of payments will be imposed as soon as possible thereafter, but not less than 15 days before the effective date of the decision;

o The public will be notified by the RO of the denial of payments at least 15 days before the effective date; and

o The current agreement will be extended during the period of the denial of payments, unless a decision is made to non-renew or to terminate the agreement before the expiration of the intermediate sanction period.

5. Fortieth Day.--Informal hearing is conducted. If the decision is adverse to the facility, the RO notifies the provider and the public of the effective date of the denial of payments. Notice to the provider and to the public is provided at least 15 days before the effective date of denial of payments.

6. Sixtieth Day.--Denial of payments is imposed. Denials should be imposed as soon as possible after notice to the facility and public that requirements are not met; i.e., 15 days later.

The sanction is imposed for 11 months. Whenever the sanction becomes effective other than on the first day of the month, it extends for the remainder of the month, as well as the automatic eleven month period that begins on the first day of the following month.

B. Resurveys

1. Credible Allegation Survey.--If the facility alleges compliance or significant progress and requests a resurvey, notify the RO. If the RO concurs that the allegation is credible, conduct a revisit to ascertain whether or not compliance has been achieved.

a. Substantial Compliance.--Notify the RO of your recommendation to lift the denial of payments. Prepare a HCFA-1539 certifying compliance. Recommend renewal of the provider agreement immediately following the expiration of the extended agreement, if compliance is maintained.

b. Significant Effort and Progress.--Prepare a HCFA-1539, certifying non-compliance. Obtain a revised HCFA-2567 for deficiencies not yet corrected, and forward that along with the HCFA-2567B to the RO, along with a brief narrative documenting the facility's progress. The RO will continue payments for new admissions if your documentation supports the findings of significant effort and progress. Documentation must affirm that:

- Remaining deficiencies do not adversely affect patient health and safety;
- There is progress in achieving compliance with all requirements; and
- All statutory-level deficiencies have been corrected.

c. Significant Effort and Progress Not Found.--If significant effort and progress cannot be documented, or if no progress at all can be documented, prepare a HCFA-1539 certifying noncompliance, prepare a HCFA-2567B, and include a brief narrative justifying your recommendation to terminate or to continue the denial of payment for new admissions.

2. Recertification Survey.--Conduct a full resurvey no later than 45 days before the extended expiration date of the agreement. If the facility is found not to meet program requirements, certify non-compliance and forward the HCFA-1539, HCFA-2567 and supporting documentation to the RO not later than 10 days following the date of resurvey.

3040. RECONSIDERATION PROCEDURES (MEDICARE)

A. Right to Reconsideration of an Initial Denial or Non-Renewal.--Reconsideration is granted administratively, not statutorily, pursuant to regulations 42 CFR 405.1510-405.1518. Any provider that is dissatisfied with an initial determination that it does not qualify as a Medicare provider may submit a request within 60 days that the Secretary reconsider the decision.

Reconsideration is a review of the determination. This review results in affirmation or reversal of the determination. Further appeal rights include hearing before an Administrative Law Judge and review by the Appeals Council.

B. Request for Reconsideration.--A request for reconsideration is any written expression of dissatisfaction with the initial decision. The request may be in the form of a letter, statement, or submittal of a new Request to Establish Eligibility and may be signed by any responsible official of the provider or by and attorney on behalf of the provider. Officially date or date-stamp any request the day of receipt in the SA.

C. Acknowledgement of Reconsideration Request.--Acknowledge the request promptly. Forward a copy of the request and acknowledgement letter immediately to the RO. The RO will advise if additional development is required. Also, forward any subsequent information received that would affect the reconsideration or hearing. If the request is filed by an attorney, send a copy of the acknowledgement to the provider. Most cases will require redevelopment by the SA, particularly if there are questions about the provider's efforts and plans to correct previously cited deficiencies. If requesting additional evidence, stipulate in the acknowledgement a reasonable deadline for submittal.

D. Documentation of the File.--A reconsideration review (following denial or nonrenewal) is not complete unless the file contains adequate documentation to fully explain every statutory deficiency and finding of non-compliance with program requirements. Send to the RO all reports of onsite visits and telephone contacts with the provider as well as any pertinent information available from the licensing agency.

E. Adverse Action Progress.--As the reconsideration develops, you may receive requests for information and status reports from the RO.

F. Medicare Reconsideration Binding Upon Medicaid.--In the case of Medicare/Medicaid SNFs, the outcome of the Medicare due process is also binding for Medicaid SNFs.

3045. APPEALS OF ADVERSE ACTIONS FOR MEDICAID SKILLED NURSING AND INTERMEDIATE CARE FACILITIES (NOT APPLICABLE TO FEDERAL TERMINATIONS OF MEDICAID FACILITIES)

Denials, terminations, cancellations, and denials of payment for new admissions to facilities participating in Medicaid-only are State administrative actions and decisions.

State appeal procedures must be made available to facilities in cases of nonrenewal, denial, cancellation, or termination of the provider agreement. It is up to the State to designate the office or official having authority to hear and decide Medicaid appeals. Although the State retains considerable flexibility in developing its own appeal procedures, the procedures must at a minimum provide for an evidentiary hearing either before or within 120 days after the effective date of the adverse action. The State must also provide an informal reconsideration prior to taking adverse action if it elects to provide a full evidentiary hearing after the effective date of the adverse action (42 CFR 431.150-153).

NOTE: In the procedures for denial of payment for new admissions (C, below), a post-termination hearing is not a permitted option. The State must provide an informal hearing before the effective date of the denial of payments for new admissions. Consequently, reconsideration is not appropriate for these appeals.

A. Informal Reconsideration.--The State may develop and implement its own reconsideration proceedings. However, the process must include:

o Timely notice of the reason for the action;

o A reasonable opportunity for the facility to refute those reasons in writing; and

o A written decision prior to the effective date of the adverse action.

B. Evidentiary Hearing.--The evidentiary hearing must include:

o Timely written notice to the facility of the findings upon which the termination or denial is based, and disclosure of the evidence on which the decision is taken;

o An opportunity for the facility to appear before an impartial decision maker to refute the basis for the decision;

o An opportunity for the facility to be represented by counsel or another representative;

o An opportunity for the facility or its representatives to be heard in person, to call witnesses, and to present documentary evidence;

- An opportunity for the facility to cross-examine witnesses; and

- A written decision by an impartial decision-maker, setting forth the reasons for the decision and the evidence on which the decision is based.

C. Informal Hearing (Applies to Ban on Payment Only).--The informal hearing process must include:

- Timely notice of the reason for the action;

- A reasonable opportunity for the facility to present in writing or in person reasons for its disagreement;

- An opportunity for the facility or its representatives to be heard in person and to present documentation; and

- A written decision by an impartial decision maker, prior to the effective date of the adverse action, setting forth the reasons for the determination. The informal hearing is not followed by an evidentiary hearing.

D. Judicial Review.--Federal regulations do not provide for judicial review of these appeals proceedings. Judicial review is governed by State law.

E. Impartial Decision Maker (Hearing Officer).--States have flexibility in selecting individuals to conduct the reconsideration and hearing proceedings. However, in both proceedings, certain individuals should be excluded from serving as decision makers.

In reconsideration proceedings, the surveyors, as well as other persons directly involved in gathering and providing evidence upon which the adverse action is based, are ineligible to make the decisions. (One person should not be both witness and judge.) However, the person who made the original determination based on the surveyors' findings is not ineligible to decide the reconsideration. If the decision is originally made at the highest level the appeal decision should also be made there. However, if the original decision is made by a regional supervisor, someone higher in authority should review the appeal.

In administrative hearings all persons directly involved in either the survey or the reconsideration process are ineligible for reasons for impartiality.

EXHIBIT 40

Model Letter Notifying Skilled Nursing Facility of Noncompliance

Provider Number: ________________

Dear: ______________________:

To participate as a provider of services in the Medicare program, a skilled nursing facility must meet all of the provisions of section 1861 (j) of the Social Security Act; be in compliance with each of the Conditions of Participation established by the Secretary of Health and Human Services; and be free of hazards to the health and safety of patients.

The (State Health Department) assists the Health Care Financing Administration by surveying skilled nursing facilities and other providers of services to determine whether they continue to meet the requirements for Medicare.

This office surveyed (Name of SNF) on (Dates of Survey) and found the following deficiencies to exist:

(List each deficiency and the alpha prefix code)

The office discussed with you the seriousness of the deficiencies and the need for you to achieve compliance. If you believe you will achieve compliance, you should submit your plan of correction to this office by (10 days from date of notice).

*Failure to correct the above deficiencies within a time limit found acceptable by the Health Care Financing Administration (HCFA), may result in a decision by the HCFA Regional Office to terminate your approval as a Medicare provider of services.

**Based on the above deficiencies, we are recommending to the Health Care Financing Administration Regional Office that your approval as a Medicare provider of services be terminated. The Regional Office will notify you of its determination.

If you have corrected these deficiencies, immediately notify this office.

Sincerely yours,

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*Use this paragraph if the SNF _is_ potentially eligible for denial of payments for new admissions.

*Use this paragraph if the SNF _is not_ potentially eligible for denial of payments for new admissions.

Exhibit 63 (Cont.)

Recertification- Medicare Skilled Nursing Facilities While Subject to Denial of Payments for New Admissions

Certification and Transmittal	HCFA-1539
Request for Certification (by surveyor)	HCFA-1516
Ownership and Control Interest Disclosure Statement	HCFA-1513
Crucial Data Extract - Health (with appropriate attachment)	HCFA-1569E
Crucial Date Extract - Life Safety Code	HCFA-2786E
Statement of Deficiencies and Plan of Correction - Health NOTE: Plan of correction may or may not be submitted by the provider.	HCFA-2567
Statement of Deficiencies and Plan of Correction - Life Safety Code	HCFA-2567
Fire Safety Survey Report*	HCFA-2786A,B,C or F
Survey Report Utilization Review Section (pp. 1 and 59-69) and Staffing Patterns (pp. 24 and 25)	HCFA-1569

Revisit After Credible Allegation - Medicare Skilled Nursing Facilities While Subject to Denial of Payments for New Admissions

Certification and Transmittal	HCFA-1539
Statement of Deficiencies and Plan of Correction (for deficiencies found not corrected)	HCFA-2567
Post-Certification Revisit Report (for deficiencies found to have been corrected)	HCFA-2567B

Recertification - Medicaid-Only Skilled Nursing Facilities and Intermediate Care Facilities While Subject to Denial of Payments for New Admissions

Certification and Transmittal	HCFA-1539
Request for Certification (by surveyor)	HCFA-1516
Ownership and Control Interest Disclosure Statement	HCFA-1513
Crucial Data Extract - Health (with appropriate attachments)	HCFA-1569E
Crucial Data Extract - Health (with appropriate attachments)	HCFA-1569E
Crucial Data Extract - Life Safety Code	HCFA-2780E
Statement of Deficiencies and Plan of Correction - Health NOTE: Plan of correction may or may not be submitted by the provider.	HCFA-2567
Statement of Deficiencies and Plan of Correction - Life Safety Code	HCFA-2567
Staffing Pattern (pp. 24 and 25)	HCFA-1569
Fire Safety Survey Report *	HCFA-2786 A, B, C or F

(The same waiver as in initial certification requires submittal of only page 1 of Fire Safety Report)

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* If FSES is applied. the following are needed: HCFA-2786D or G for all zones, and Table 8 for the entire facility. Do not send LSC Survey Report to RO if it is a HCFA-2786A, B or F _and_ _no_ _use_ of FSES or waivers

Exhibit 63 (Cont.)

Revisit After Credible Allegation - Medicaid-Only Skilled Nursing Facilities and Intermediate Care Facilities While Subject to Denial of Payments for New Admissions

Certification and Transmittal	HCFA-1539
Statement of Deficiencies and Plan of Correction (for deficiencies found not corrected)	HCFA-2567
Post-Certification Revisit Report (for deficiencies found to have been corrected)	HCFA-2567B